HIPAA Meets Lawsuits, Controversy — PAGES 10-11

Health Care News

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SURVEY

Americans Want Health Care Choice

BY CONRAD F. MEIER

A new survey, commissioned by Communicating for Agriculture and the Self-Employed (CA) and conducted by Strategic Research Group of Minneapolis, reports emphatically that Americans want more freedom in health care.

"An overwhelming 86 percent of those responding to the survey told us they want more freedom to choose the type of health plan they want, including ones that reduce the amount of coverage they have," said Wayne Nelson, president of CA.

Americans like the idea of tax credits as an incentive to increase the number of individuals and families with health insurance, but they don't think too highly of the Patients' Bill of Rights.

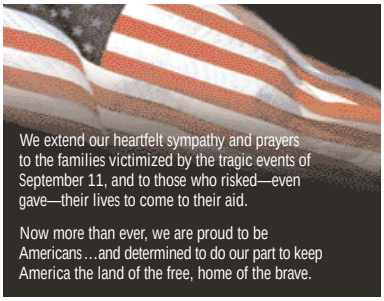
When asked whether Congress should pass legislation giving them the right to sue their health care plans, or pass legislation creating a tax credit for health insurance, 79 percent of respondents said they would rather have a tax credit.

Support for the tax credit went up to 86 percent when respondents were specifically asked about proposed tax credit legislation, which would grant credits of up to $1,000 per individual and up to $3,000 for a family, with the funds to be used to pay for private health insurance premiums.

Debby Podolsky is the sole employee of her company. New Florida laws require her to enroll in a managed care health plan or wait a year before getting coverage. *photo/KRT*

"There is no question that the vast majority of Americans want more choice and tax credits for individuals—not just employers—to purchase health insurance," said Nelson. "Yet most legislative assumptions are that almost all health insurance is employer-

CHOICE continued on page 17



We extend our heartfelt sympathy and prayers to the families victimized by the tragic events of September 11, and to those who risked—even gave—their lives to come to their aid.

Now more than ever, we are proud to be Americans…and determined to do our part to keep America the land of the free, home of the brave.

America's Uninsured Population Overstated

If legislators are using bad data to develop strategies to address the nation's uninsured rate, the resultant policy is likely not only to fail, but to make matters worse

BY CONRAD F. MEIER

Since the early 1980s, the U.S. Census Bureau has used questions in its Current Population Survey (CPS) to arrive at estimates of the uninsured population. The Census Bureau estimates have consistently been higher than other estimates, such as those produced by the Urban Institute.

Now, the Census Bureau has recalculated its estimate, and it reports the uninsured problem may be less severe than previously thought.

- The new count of the number of uninsured in 1999 reduces the number from 42.6 million to 39.3 million—a difference of 3.3 million people.
- According to researchers, "private [health insurance] coverage appears to be the type of coverage most affected by reporting differences between the CPS and other surveys."

What's a "Household"?

Contradictory answers given by CPS survey respondents help explain why the Bureau had to revise its estimate downward. Some respondents, who initially said they or someone in their house-

UNINSURED continued on page 12

Individual Insurance: Solution for the New Economy?

MERRILL MATTHEWS JR., PH.D.

The employer-based health insurance system was born during World War II, when the economy and the health care system were very different than they are today. That system worked well for a while, providing millions of working Americans with good health insurance and good health care.

But over the past decade, the limitations of employer-based health insurance have become increasingly apparent.

A health insurance system created at a time when workers—almost always the husband—held one full-time job, often in a factory and usually for relatively long periods of time, may be an anachronism today, when both husband and wife often work, not for one company, but several jobs, or are self-employed.

And it has no relevance to the growing population of Americans who lack health insurance and so must rely on personal resources, government programs, or the charity of others when they need medical attention.

In short, a New Economy demands a new health insurance model.

Role of the Tax Code

We have an employer-based health insurance system in the U.S. today largely because of the tax code.

During World War II, employers began to offer

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MY TURN

AN EDITORIAL BY CONRAD MEIER

Improving Accountability in Congress p.18

The Heartland Institute
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Health Care News

EDITORIAL OFFICES
The Heartland Institute
19 South LaSalle
Suite 903
Chicago, Illinois 60603
312/377-4000 voice • 312/377-5000 fax
email think@heartland.org

PRESIDENT
Joseph L. Bast

PUBLISHER
Nikki Saret

EDITOR
Diane Carol Bast

MANAGING EDITOR
Conrad F. Meier

ASSISTANT EDITORS
Greg Scandlen
Merrill Matthews

CONTRIBUTING EDITORS
Twila Brase, Bob Corkins
Dewey L. Crepeau, Dr. Miguel A. Faria
Tom Miller, Gerry Smedinghoff
Grace-Marie Turner

CARTOONISTS
Mike Shelton
Chuck Asay

DESIGN AND PRODUCTION
Kevin Fitzgerald
Jennifer Beranek

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PhRMA Asserts itself in Court Action

BY CONRAD F. MEIER

The Pharmaceutical Research and Manufacturers of America (PhRMA) said it will ask the U.S. Supreme Court to overturn a federal appellate court ruling upholding Maine Rx, further delaying implementation of the state's prescription drug discount program, according to the *Bangor Daily News*.

As previously reported in *Health Care News* (see "Drug Wars in Maine," April 2001), Maine Rx is a first-of-its-kind program permitting the state to act as a pharmaceutical benefits manager for the 325,000 Maine residents who lack prescription drug insurance coverage.

Under the Maine Rx program, the state would negotiate with pharmaceutical companies to obtain prescription drug rebates equal to or greater than those set by federal law for the Medicaid program. The state would then pass the rebate on to pharmacies, which would give the discount to Maine Rx participants.

In August 2000, PhRMA filed a lawsuit against the state, alleging the law was unconstitutional because it regulated out-of-state commerce and conflicted with federal Medicaid law. A federal judge granted a preliminary injunction barring the state from implementing the law, but the First U.S. Circuit Court of Appeals lifted that injunction in May.

In June, the appellate court rejected a PhRMA motion to reinstate the injunction. Maine Human Services Commissioner Kevin Concannon said PhRMA's decision to appeal that ruling to the U.S. Supreme Court was disappointing, but he expressed confidence the state would eventually prevail in the case.

The Court was expected to hear PhRMA's request in October. If it decides not to hear the case, the injunction will be lifted and the program implemented.

PhRMA Sues in Florida

PhRMA has also filed suit against the state of Florida, seeking to block a new law that requires pharmaceutical companies to provide discounts to have their drugs placed on the state's Medicaid formulary.

The suit was filed on August 7 in federal court in Tallahassee. PhRMA argues the Florida law violates a federal statute requiring states to offer all prescription drugs to Medicaid beneficiaries "unless [according to the statute] there is a written finding that the drug offers no clinically meaningful benefit."

The suit names Florida Medicaid head Bob Sharpe and state Agency for Health Care Administration Secretary Rhonda Medows as defendants. Jan Faiks, PhRMA assistant general counsel, told the *South Florida Sun-Sentinel*, "They are restricting patients' access to drugs not for medical, clinical reasons but for money reasons."

PhRMA says only 821 of the 1,827 brand-name medicines covered by Medicaid appear on Florida's drug formulary. Under the Florida law, passed in May 2001, doctors may prescribe drugs not on the formulary, but they must call a phone bank of pharmacists for approval—a requirement, according to a *Wall Street Journal* report, "expected to prompt many physicians to prescribe drugs on the formulary."

In a September press statement, Gov. Jeb Bush responded to the suit by saying "large profit margins for multibillion dollar pharmaceutical companies is not a priority for the state. I guess I'll take it as a badge of honor that I'm being sued by the big drug manufacturers about what's right."

But "prescription medicines are an essential part of health care," noted PhRMA in a press release announcing the lawsuit's filing. "All citizens should have unrestricted access to the medicines they need."

For more information…

WWW The full text of the press release announcing the PhRMA Florida lawsuit is available on the association's Web site at **http://www.phrma.org/press/newsreleases//2001-08-07.255.phtml.** You will find links there to a backgrounder and the full text of the complaint.

Michigan Seniors Eligible for New Rx Program

BY VICKI LANKARGE

Low-income seniors already enrolled in the state of Michigan's prescription drug assistance programs will be given the first opportunity to sign up for a new one, says a state health official.

Members of the Michigan Emergency Pharmaceutical Program for Seniors (MEPPS) and the state's Prescription Drug Tax Credit program will be the first to be eligible for year-round prescription drug coverage under the state's new Elder Prescription Insurance Coverage (EPIC) program, according to James K. Haverman, director of the Michigan Department of Community Health.

"The benefits in the EPIC program are much broader than those currently available to seniors in need," says Lynn Alexander, director of the Michigan Office of Services to the Aging.

The EPIC program will cover most prescription drugs approved by the Food and Drug Administration, including insulin and syringes. According to Haverman, there will be a monthly co-payment based on an individual's income. To be eligible, low-income seniors must *not* be enrolled in Medicaid. Seniors who are enrolled in Medicare are eligible as long as they do not have any other form of prescription drug coverage.

Seniors who have received MEPPS benefits in the current fiscal year and who also enroll in EPIC will begin receiving EPIC benefits on October 1.

The next group to be enrolled will be those who received the senior tax credit this tax year. According to Haverman, this group can expect to begin receiving enrollment information in the mail in October. Those who qualify from this second group will begin receiving EPIC benefits on December 1.

Open enrollment will follow and will be dependent on fund availability.

EPIC will eventually be open to all Michigan residents age 65 and over who aren't enrolled in Medicaid and who meet income eligibility requirements.

Vicki Lankarge is a health insurance reporter for Insure.com.

CORRECTION

In the July installment of "The Pulse," we incorrectly identified the Conference on Transformative Change through Market-Driven Health Care as being The Galen Conference, and compounded our error by failing to properly credit all the sponsors. The conference was co-sponsored by the National Center for Policy Analysis, the American Medical Association, the United States Chamber of Commerce, and The Galen Institute.

Greg Scandlen points out that one of the most important aspects of the conference was the cooperation of the AMA and U.S. Chamber on matters relating to free markets. Given the past tension between these two influential groups over the Patients' Bill of Rights, getting them to sit together was a herculean effort.

HCN regrets its error.

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The Pulse

BY GREG SCANDLEN

Free-market health care reform in the news

It's not been easy getting back to work after the events of last month. We have all been affected by the attack, directly or indirectly. Before the attack, something as simple as the sudden closing of National Airport would have seemed a catastrophe. Today it seems almost trivial.

The United States has been changed. To the extent we have been shaken from our complacency and our petty bickering, it will be for the better. To the extent we rediscover the role of government is to ensure the public safety, not to act as our nanny, it will be better still.

This does connect to health care reform. The police, firefighters, and construction workers of New York City have proven to be more competent than the CIA and FAA. Who would dare say they are incapable of choosing their own health care coverage anymore? Who would suggest the federal government should take care of it for them?

MN CHAMBER: WORKERS WANT MORE CHOICE

Americans are quite confident in their own abilities, according to a survey of employers and employees conducted by the Minnesota Chamber of Commerce.

The survey found that 77 percent of employers and 78 percent of employees favor the idea of workers customizing their own benefits; 75 percent of employers and 71 percent of employees favor financially rewarding workers for controlling their use of benefits; and 52 percent of workers like the idea of "choosing their own coverage with only financial assistance from their employer."

Source: Contact Annamarie Hingos of the Minnesota Chamber of Commerce at 651/292-4694 or ahingos@mnchamber.com.

SURVEY: WORKER SATISFACTION LESS IMPORTANT

A Kaiser Family Foundation survey of employers on their benefits programs confirmed what many employees already suspected. KFF is actually just the latest sponsor of this survey, conducted annually by Jon Gabel. Gabel is employed by the Health Research and Educational Trust, an off-shoot of the American Hospital Association.

Gabel started doing this survey many years ago, when HIAA sponsored it. There is nothing very surprising in the latest version: PPO enrollment is going up while HMO enrollment is going down; costs are rising faster than at any time since 1992; large employers have more savvy than small employers; etc. etc.

One thing of interest is that employers are paying much less attention to employee satisfaction than they used to in choosing a benefit plan. Only 47 percent of employers responding to the survey said employee satisfaction was a "very important" consideration. Also, almost no one pays attention to NCQA or HEDIS quality measures when choosing a plan.

The KFF survey also finds that a mere 17 percent of firms, including only 41 percent of "jumbo" firms (5,000+ workers), "have the ability to link medical care data to individual employees," which is a requirement of HIPAA effective October 16, 2002—just a year from now.

The report is good background information and is available at the Kaiser Web site.

Source: "Employer Health Benefits," http://www.kff.org

NBCH: EMPLOYERS SKEPTICAL OF CHANGE

A report titled "Alternative Strategies for Managing Employee Health Benefits" was issued by the National Business Coalition on Health (NBCH) in September. The report—a recap of a meeting NBCH held in January—takes what it styles a stance of "healthy skepticism" towards new ideas.

The report emphasizes, for instance, a Deloitte Touche survey that concluded 80 percent of employers are not considering any significant changes in the way they purchase health benefits. Fifty-nine percent of those said they wouldn't change because of employee resistance. (It is interesting how often employers underestimate their workers' willingness to change.)

NBCH also offered its own definition of "defined contribution," which emphasizes a "fixed" contribution from the employer. The report includes extended summaries of presentations by Randy Johnson of Motorola and Pam Krol of Lucent Technologies. Both firms are being cautious in embracing change, looking at more quality assurance, use of technology for information support, and outsourcing of benefits administration. Generally, the report is pretty negative on defined contribution.

Source: http://www.nbch.org

EBN: MODELS FOR DEFINED CONTRIBUTION

Much more upbeat on defined contribution is the first in a two-part series in *Employee Benefit News*, by Jill Elswick. The article lists five different business models as defined by the new Consumer Driven Health Care Association, and indicates which of the association's members fit into each model.

Elswick says all the models are "miles from the vilified notion of tucking grimy wads of cash into employees' hands and ordering them to buy coverage on the back streets of the individual health insurance market." "Paternalism survives," she adds, "but with a twist."

Source: "Business Models Emerge for Consumer-Driven Health Care," September 1, 2001, http://www.benefitnews.com

CONSUMERS NEED "SKIN IN THE GAME"

The *Charlotte (North Carolina) Observer* says "consumers don't have enough skin in the game," in a report on a recent meeting of the local Association of Health Underwriters. A panel of speakers told the group that the essential problem in health care is that "the consumer is not the payer."

The article concludes, "health-care types are hot on medical savings accounts and other 'defined contribution' plans."

Source: "Group Discusses How to Control Health-Care Costs," Mike Stobbe, September 8, 2001, http://www.charlotte.com/

GOODMAN ON HEALTH REFORM

NCPA President John Goodman was interviewed by Linda Seebach in the *Rocky Mountain News* in early September. He covers a lot of health care ground, including the problems created by misguided regulations and the need for more consumerism in health care. He offers "flexible spending medical accounts" as a step in the right direction.

Source: "Free-Market Thinking About Health-Care Policy," Linda Seebach, September 8, 2001, http://denver.rockymountainnews.com/archive

FORTIS SEES SURGE IN MSA SALES

Fortis Vice President Scott Krienke expects a surge in MSA sales if the expansion provisions in the PBOR are enacted, according to an article on BestWire. Krienke says Fortis currently has about 30,000 MSA policies in force, representing 10 to 15 percent of new sales for the company. He said the limits placed on the current program by Congress have depressed sales. "The temporary nature of this has really stifled the general awareness of the product throughout America," he said.

Krienke believes the expansion would create more competition, but also inspire Fortis' own agents to market MSAs harder.

Source: Contact Dennis Kelly at dennis.Kelly@ambest.com for a copy.

MYHEALTHBANK KICKING IN WASHINGTON

MyHealthBank is being well-received in Washington state, according to a press release from the company. The release quotes the president of Wilson Oil of Longview, Washington as saying his employees are very happy with the new range of choices available. Some are adding their own funds to improve their coverage, while others are putting money into their Health Freedom Accounts to cover gaps in their coverage. He says the program didn't cost his company extra but still provides excellent coverage for employees.

Source: Contact Becky Engel at 503/222-0626 or bengel@youngroehr.com.

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis in Dallas, Texas. To sign up for his free weekly e-newsletter, Scandlen's Health Policy Comments, log on to www.ncpa.org/sub/. Scandlen can be contacted by email at GMScandlen@aol.com.

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HIAA Supports Private-Sector LTC

BY CONRAD F. MEIER

The Health Insurance Association of America (HIAA) is promoting "Americans Planning for Today and Tomorrow," a grassroots campaign designed to build stronger and broader support for the Long-Term Care and Retirement Security Act of 2001. To date, HIAA's media campaign and lobbying efforts have produced 147 cosponsors for H.R. 831 and 16 co-sponsors for S. 627.

S.627, sponsored by Sen. Charles E. Grassley (R-Iowa), would amend the Internal Revenue Code of 1986 to allow:

- a deduction (based on years of continuous coverage) for eligible long-term care insurance premiums for a taxpayer, spouse, and dependents, including accelerated deduction percentages for persons who are 55 years old;
- long-term care insurance to be offered under cafeteria plans and flexible spending arrangements; and
- an income-adjusted credit (up to $3,000) for eligible individuals with long-term care needs and their caregivers.

"Largest Looming Expense"

In a news release describing the HIAA campaign, the group's interim president, Donald A. Young, MD, notes, "For America's 77 million baby boomers, paying future long-term care costs remains as their largest looming expense. According to the Bureau of the Census, in 2020, one out of every six Americans will be age 65 or older—roughly 20 million more seniors than today."

By 2020, Young added, "the number of Americans 85 and older—the people most likely to use long-term care—will double to 7 million, and double again to 14 million by 2040. Meanwhile, the national average annual cost of a nursing home stay is about $50,000."

Stephen A. Moses, president of the Center for Long-Term Care Financing, told *Health Care News* in an email interview, "Without strong tax incentives to encourage baby boomers to plan early and insure fully for long-term care, many of this 77-million mega-generation will fall into Medicaid by default as their parents and grandparents did, thus administering the final coup d'grace to America's welfare-financed, institution-based long-term care system."

Better than Medicaid

Walter M. Cadette, a senior scholar at The Jerome Levy Economics Institute, writes in *Financing Long-Term Care*:

"The nation is not equipped to deal with this problem. By default more than by design, it has fashioned a welfare model for financing long-term care, pushing Medicaid far afield of its original purpose of providing for the medical care of the indigent."

Cadette notes that most long-term care is financed in one of two ways. Persons with substantial savings finance the care out-of-pocket. Medicaid covers the rest: the poor as well as the not-so-poor who have "spent down" their assets. "More than a third of the Medicaid budget goes to long-term care," he points out, "mostly to pay for stays in nursing homes. Medicaid pays, in whole or in part, for the care of two out of three nursing-home residents."

> **"Insurance—public or private or some combination of the two—would be a far better way [than Medicaid or Medicare] to meet the nation's long-term care needs."**

Private insurance, notes Cadette, finances just 7 percent of long-term care. But insurance—public or private or some combination of the two—would be a far better way than Medicaid to meet the nation's long-term care needs. He considers long-term care "almost perfectly suited" to an insurance model: an extended nursing-home stay is a low-probability but high-consequence event—the classic insurance risk.

So if insurance is the best long-term care option, why do so few people cover long-term care that way? For three reasons, according to Cadette:

- Many Americans believe Medicare will pay for long-term care. In fact, however, Medicare reimbursement is limited to short stays for rehabilitation after an acute illness.
- Because long-term care insurance is low on the priority list of middle-aged and young adults, the insurance pool is narrowed to those for whom long-term disability is a distinct possibility—something that greatly increases premiums. Administrative costs are also inordinately high.
- Adverse selection makes it even harder for insurers to generate economies from pooling. When insurers cannot readily distinguish low risks from high, the coverage they offer to low-risk consumers is too little to be attractive to high-risk consumers. Alternatively, adequate coverage for high-risk consumers is too expensive to appeal to low-risk consumers.

By 2020, Young added, "the number of Americans 85 and older—the people most likely to use long-term care—will double to 7 million, and double again to 14 million by 2040. Meanwhile, the national average annual cost of a nursing home stay is about $50,000."

The solution, Cadette says, is to attract consumers when they are relatively young, before health problems that might give rise to the need for long-term care begin to surface. "The earlier the insurance is bought, the less the insured will know about the risk of disability later in life, which will limit adverse selection and make it less difficult for buyer and seller to strike an equilibrium price."

LTC Bills an "Opportunity to Act"

Moses, at the Center for LTC Financing, agrees. "The only way to save Medicaid for the poor is to divert middle-class boomers to LTC insurance now, while they are still young enough, healthy enough, and affluent enough to afford the premiums. Congress and President Bush are penny-wise, pound foolish if they miss this last, viable opportunity to act."

The long-term care policies subject to the deduction in the proposed bills are covered by broad consumer protections. The bills also would permit long-term care insurance policies to be offered under employer-sponsored cafeteria plans and flexible spending accounts.

LTC continued on next page

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LTC continued

Together, these initiatives have the potential to help millions of Americans who need long-term care services now and in the future.

Studies indicate roughly 40 percent of long-term care in this country is paid for by individuals needing care, their families, the insurance they purchase, or through other private sources.

The main providers of long-term care continue to be family members—typically wives and daughters. Many older people who need long-term care today are maintaining some of their independence by relying on family members for assistance.

While the LTC tax credit would not reach many modest-income individuals in need of long-term care, it would provide relief for many family caregivers. Caregivers often lose wages and benefits, sometimes even jobs, to care for their loved ones. In short, caregivers may give up their own future income security to provide long-term care today for a mother or mother-in-law.

For more information…

WWW The full text of Walter A. Cadette's May 2000 analysis, *Financing Long-Term Care*, can be found on the Internet at **http://www.levy.org/docs/hili/59a.html**.

Beyond HIPAA

The tax clarifications enacted as part of the Health Insurance Portability and Accountability Act of 1966 (HIPAA) are a good first step, but they have limits. Due to the limitations imposed on the medical itemized deduction, HIPAA's tax benefits help primarily those workers whose employers contribute toward a long-term care insurance policy on their behalf.

According to employee benefits research, this represents only 2 percent of the current long-term care insurance market. The vast majority of Americans who have long-term care insurance purchase individual policies and may deduct LTC insurance premiums only if they itemize deductions and only if their medical expenses exceed 7.5 percent of adjusted gross income. IRS data show only 4.5 percent of all tax returns report medical expenses as itemized deductions.

The pending legislation goes beyond HIPAA and updates the consumer protection standards to reflect most of the National Association of Insurance Commissioners' model act and regulations on long-term care as amended in September 2000.

During the August break, the HIAA campaign mobilized a growing and diverse coalition to reach out to members of Congress with letters, phone calls, personal visits, and town hall meetings. The coalition is made up of consumers, other interested organizations, long-term care providers, and insurance agents and brokers.

The campaign focuses on grassroots consumer education and activation and is part of HIAA's effort to bring about tax relief for consumers to help them protect themselves against the high cost of long-term care. The goal is to ensure passage of S. 627 and H.R. 831.

Leapfrog Group Recognized for Efforts to Reduce Medical Errors

For more information…

WWW Contact John Schachter of The Business Roundtable at **202/872-1260**.

BY CONRAD F. MEIER

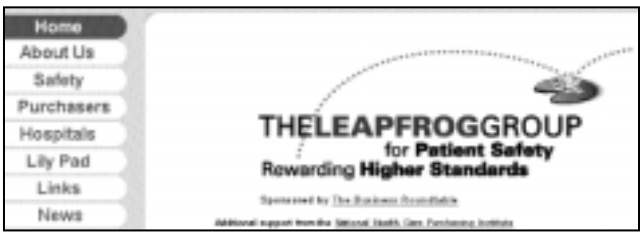
The Business Roundtable's "Leapfrog Group" has received the esteemed Ellwood Award for outstanding efforts to foster consumer-focused accountability in health care.

The innovative Business Roundtable (BRT) initiative won the award for its commitment to reducing medical errors by leveraging the health care purchasing power of major employers and public health care purchasers.

Launched in November 2000, the Leapfrog Group is a growing consortium of Fortune 500 companies and other large health care purchasers who have committed to a common set of purchasing principles to drive "leaps" in patient safety. The group's approximately 80 members provide health benefits to more than 25 million Americans, and with their employees spend more than $45 billion annually on health care.

Health Care News first reported the activities of the Leapfrog Group in March 2001, noting the billions of dollars spent on health care services by Leapfrog Group employer-members represents significantly more clout and potential for improvements than all the increased rules and regulations being issued by Washington bureaucrats.

Leapfrog Group members offer incentives to health care providers who adopt proven patient safety measures. Those measures include computerized physician order entry, evidence-based hospital referral, and intensive care unit (ICU) staffing by physicians trained in critical care medicine.



Members have also agreed to alert the health care industry that big leaps in patient safety and customer value will be recognized with preferential use and intensified market reinforcements.

Accepting the award were John J. Castellani, president of the BRT, and Suzanne Delbanco, Leapfrog's executive director.

"We are pleased that The Leapfrog Group is receiving this prestigious award," said Lewis B. Campbell, chairman of the BRT Health and Retirement Task Force and chairman and CEO of Textron Inc. "We officially launched this BRT initiative to reduce preventable medical errors just six months ago, and we have already been enormously successful in getting employers committed to the effort.

"Leapfrog has received the enthusiastic support of the business community and is well on its way to educating consumers and improving the caliber of care furnished to millions of Americans.

"Medical errors have been responsible for too many preventable deaths and injuries," Campbell continued. "By bringing employers together through BRT's Leapfrog Group, we have the opportunity to lead the way in ensuring patient safety and quality health care for employees and their families nationwide. The purchasing power of public and private employers has the potential to greatly reduce medical errors."

The Ellwood award is presented by the Foundation for Accountability to organizations whose efforts demonstrate outstanding leadership, action, vision, and teamwork in improving the health care system for consumers. The awards are given annually in honor of Paul Ellwood, M.D., founder of the Jackson Hole Group.

Defined Contribution Gains Momentum

BY GREG SCANDLEN

Defined contribution continues to make slow inroads into the benefits market.

We previously reported MyHealthBank is entering the Washington market and UNICARE is entering Illinois. Now, UNICARE has announced it is also entering Indiana.

Definity Health has just inked a deal with Rhode Island-based Textron to provided benefits to about 1,700 of its 45,000 employees. Ultimately, the program will reach all Textron employees. Definity's product is very much like a Medical Savings Account for large employers, with a lot of online consumer support. Textron joins Medtronics, Aon Corporation, the University of Minnesota, and Dade Behring on Definity's list of major accounts.

New Hampshire-based Choicelinx has entered an agreement with McKesson Health Solutions to provide medical management and patient advocacy services to help employees self-manage their health and benefits. No word yet on whether Choicelinx is actually selling any product.

American Medical News reports on a defined contribution conference held in Chicago. Staff writer Julie Jacobs writes, "managed care in its current form is nearing the end of its life cycle, and whatever form of health insurance takes its place will give consumers much more control and choice over their health benefits."

According to Jacobs, most of the speakers at the Global Business Research conference expect the next wave to be a modified version of the existing system, rather than a radical switch to a full-blown defined contribution.

Jacobs also pointed out, as we have in *Health Care News* (see "The Pulse," September 2001), that there appears to be a serious disconnect between managers—who doubt their employees' ability to make health care decisions—and employees themselves, who are very eager to have a choice of health care plans with different levels of employee contributions and benefit levels.

Defined Contribution and Financial Institutions

Booz-Allen Hamilton is focusing more on the opportunity presented to financial institutions by the switch to defined contribution.

In a new report, "The Next Trillion Dollar Opportunity," authors Gary Ahlquist, Phillip Lathrop, and David Knott point out that defined contribution will create 50 to 100 million new individual investment accounts, and that financial institutions will probably service the bulk of these accounts. Those firms will also be able to co-market online checking, credit cards, mortgages, and other lines of insurance as well.

Ahlquist et al. mention that a British firm is already eye-balling the potential market, and that other players are more likely to come from the banking and investment communities than from health insurance companies.

Silicon Valley is looking closely at defined contribution, according to a story in the *San Jose Business Journal*. The story features a real estate firm, BT Commercial, that changed its benefits from a single Lifeguard plan to a menu of options that includes Aetna/USHealthcare, HealthNet, Cigna, and Blue Shield of California. The package was assembled by broker eGroupBenefits.

> **"Booz-Allen Hamilton . . . point[s] out that defined contribution will create 50 to 100 million new individual investment accounts, and that financial institutions will probably service the bulk of these accounts."**

Greg Scandlen is senior fellow in health policy at the Dallas, Texas-based National Center for Policy Analysis and assistant editor of Health Care News.

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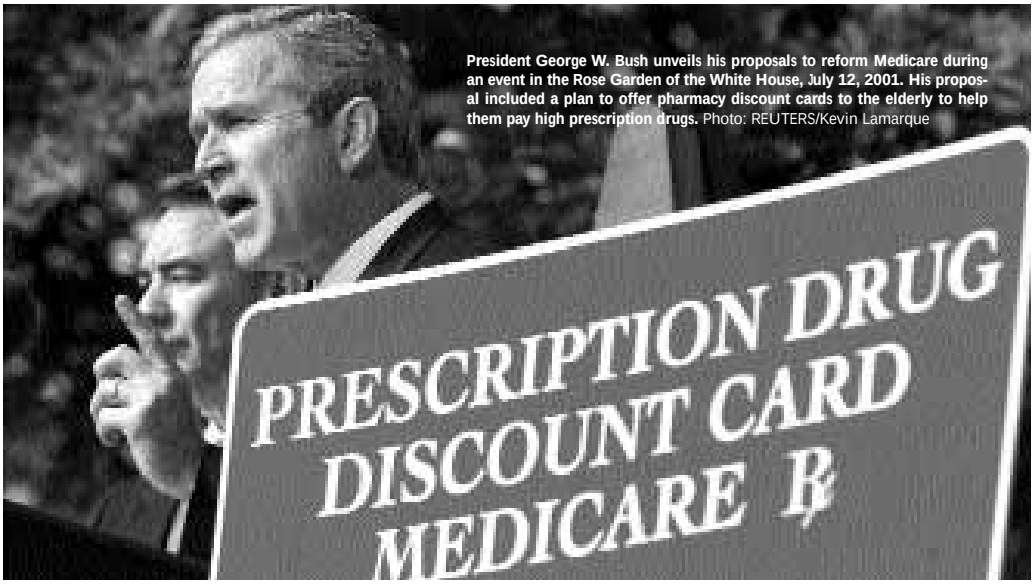

President George W. Bush unveils his proposals to reform Medicare during an event in the Rose Garden of the White House, July 12, 2001. His proposal included a plan to offer pharmacy discount cards to the elderly to help them pay high prescription drugs. Photo: REUTERS/Kevin Lamarque

Rx Discount Card Plan Stalled by Judge

Pharmacy groups win victory in suit against Bush program

BY CONRAD F. MEIER

A federal court on September 6 blocked President George W. Bush's plan to offer prescription drug discount cards to elderly Americans by early next year. The court found the administration may have lacked the authority to create the program without congressional approval.

The injunction—delighting pharmacy trade groups that had lodged a lawsuit opposing the discount cards—came weeks before federal health officials had planned to take the first significant step to put the program in motion. While the decision by Judge Paul Friedman of the U.S. District Court of the District of Columbia does not necessarily kill the plan, it will, according to the Department of Health and Human Services (HHS), postpone the program's implementation for months.

Friedman predicted the pharmacy groups had a "substantial likelihood of success" on two grounds: that the administration lacked the legal authority to create the program, and that it had not followed the proper rules for making regulations.

White House spokesman Scott McLellan told the *Washington Post*, "[The] court decision is a loss for America's seniors. The delay impacts seniors unable to get the same drug discounts other Americans receive through private health plans."

Moving Too Quickly

Grace-Marie Turner, president of The Galen Institute, told *Health Care News*, "The administration hoped to speed access to drug discounts for seniors by giving a Medicare endorsement to existing prescription drug discount cards. It quickly became clear that even something as seemingly simple as a Medicare stamp-of-approval for an existing service was very complicated to implement. And it angered an important political constituency, namely pharmacists."

Turner predicts the discount card battles will continue in the courts. She believes the administration and Congress are setting their sights now on creating a new Medicare prescription drug benefit. "It's extraordinarily important," says Turner, "to get this right so the remarkable progress in development of new medications continues."

Dr. Merrill Matthews, a visiting scholar with the Institute for Policy Innovation and policy director for the American Conservative Union Foundation, warns the delay of the Bush plan may open the door for an even more intrusive government program. He explained,

"The administration's discount card was an attempt to undermine an expensive new entitlement program being pushed by Democrats by giving seniors access to prescription drugs at somewhat lower prices. The judge's ruling will doubtless re-energize Democrats' call for a comprehensive federal program—now."

At the time of this writing, HHS officials were reviewing their legal options and had not decided whether they would appeal the injunction. "Our goal remains to provide discounts to millions of seniors as soon as possible," said Tom Scully, administrator of HHS Centers for Medicare and Medicaid Services (CMS), in a statement issued immediately after the judge's decision was announced.

First Step in Medicare Reform

The Rx discount card program represents what President Bush has called "the first necessary step" in a broad framework for modernizing Medicare and including a prescription drug benefit. Currently, Medicare pays for medicine prescribed to persons being treated as hospital inpatients, but not for medications people take at home.

The Bush plan relies on private companies managing drug benefits to buy prescription drugs in bulk. Companies would offer Rx discount cards for a premium or fee to any Medicare patient who wanted one. In turn, patients could take their cards to pharmacies across the country to buy medicine at reduced prices.

The program is opposed by two organizations representing pharmacies, which sued HHS five days after Bush's original announcement. As reported in the August 2001 issue of *Health Care News*, the National Association of Chain Drug Stores and the National Community Pharmacy Association alleged the program is illegal. They contend health officials created the plan in "secret meetings," failed to allow the public participation required in drafting regulations, and lacked legal authority.

Some 28 pharmacy benefits companies have told federal health officials they would like to take part. CMS has been reviewing their applications and had planned to announce in October which ones it would endorse. After the endorsements, the companies could have started marketing their cards to Medicare patients.

The pharmacy groups have contended that, based on the experience of discount cards already available in the private market, the savings would be relatively small. A Kaiser Family Foundation study lending strength to that argument was released in August. (See "Medicare Drug Plan May Deliver Less than Expected," *Health Care News*, September 2001.)

On behalf of HHS, Justice Department attorneys argued the agency had proper legal authority, even without explicit approval from Congress, because the new program would be related to Medicare, even though the discount cards would not actually be covered by Medicare. The government further argued HHS was not actually regulating private pharmacy discount programs, but merely creating a voluntary program for companies and patients.

The court ruling surprised both sides of the issue, as Friedman rarely delivers oral decisions at the end of court hearings. He chose to block the administration's plans on an emergency basis, noting harm would be done if HHS were permitted to go ahead with plans to choose which companies could participate in the program.

500,000 Seniors to Lose Medicare+Choice Insurance

Health care inflation outstrips federal Medicare reimbursements by a wide margin

BY VICKI LANKARGE

Health care costs that outstrip federal reimbursements by a 6-to-1 margin are mostly to blame for the health insurance industry's decision to drop 500,000 seniors from their Medicare+Choice health insurance plans next year, according to Karen Ignagni, president of the American Association of Health Plans (AAHP).

Ignagni, who held a press conference on September 21 to address the erosion of the federal Medicare+Choice program, said the number of seniors who will be affected by the withdrawal of health plans from the senior market in 2002 is roughly half the number affected in 2001.

She said there are still "fundamental problems" with the Medicare+Choice program. "Beneficiaries were promised a program of choice," she said, "but they are finding that choice elusive."

Congress created the Medicare+Choice program as part of the Balanced Budget Act (BBA) in 1997. It offers seniors the opportunity to enroll in HMOs that provide prescription drug benefits; traditional fee-for-service Medicare provides no prescription drug coverage.

Health plans blame the BBA for handcuffing them with an unprofitable annual cap of 2 percent on reimbursement increases. This cap is considerably less than the current medical inflation rate of 11 percent.

Congress did temporarily increase the reimbursement rate cap to 3 percent in some regions of the country this year, in an effort to stem the rising tide of health insurers defecting from the market. But Ignagni noted the rate will revert back to 2 percent in 2002 unless Congress intervenes.

Hardest hit by the health plans' flight from the Medicare HMO market will be seniors living in the Northwest and Southwest, regions of the country where reimbursements remained capped at 2 percent.

While some health insurers have declined to discuss plans to exit the market, PacifiCare, the largest Medicare HMO with 995,000 members, has said it will drop more than 26,000 patients in eight Western states. United Healthcare has said it will abandon Arkansas entirely and close some programs in Ohio, Florida, and Illinois, affecting nearly 57,000 members.

Even for the approximately 5 million other seniors who will not be dropped by their Medicare HMOs, the news is not much better. According to Ignagni, many of these beneficiaries will face benefit changes and higher premiums as a result of a federal funding shortfall that threatens to cripple the program.

Vicki Lankarge is a health insurance reporter for Insure.com The Consumer Guide.

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BY CONRAD F. MEIER

America Responds: Health Care in Its Finest Hours

What could easily have been utter chaos in the hours immediately following the September 11 terrorist attacks on New York City and Washington, DC in fact was nothing less than the finest hours of medical service by health care professionals, firemen, police officers, and paramedics. The cooperation between the private sector and government agencies provides dramatic evidence our health care system is still the best in the world.

Disaster Teams at the Ready

In less than an hour, the Department of Health and Human Services (HHS) activated disaster teams in an unprecedented effort to respond to the thousands of injuries and fatalities resulting from the terrorists' attacks on the World Trade Center (WTC) and Pentagon.

For the first time ever, HHS Secretary Tommy Thompson activated all 80 of the nation's special disaster teams, established precisely to respond to national disasters, plane crashes, and bombings. Some 7,000 private-sector health personnel serve on those teams, and they were prepared to go to the WTC or the Pentagon if called upon.

Thompson also advised burn unit teams, surgery units, forensic doctors, and dentists to "be ready" to go to the disaster sites. By Wednesday afternoon, four teams of doctors and paramedics were en route to Stewart National Guard Base in Newburgh, New York, north of New York City, and three teams went to the Anacostia Receiving Center in Washington, DC.

Each team consists of 35 physicians, nurses, and emergency medical technicians, plus enough equipment and supplies to make the team self-sufficient for 72 hours. The primary responsibility of each team is to perform triage and treat trauma victims at the disaster site.

Besides the medical teams, mortuary teams consisting of morticians, anthropologists, and forensic investigators—four to New York, three to Washington—were dispatched to identify victims and prepare them for burial.

By late Wednesday, the Military Sealift Command had dispatched the USNS Comfort to New York. A hospital ship carrying 935 medical and support personnel, the Comfort can treat at least 500 people.

HHS officials also worked with the Federal Emergency Management Agency (FEMA), as well as health officials in New York and Virginia, to "assess medical needs and provide medical and emergency personnel," according to an HHS news release issued September 11.

The Department of Veterans Affairs made available many emergency beds in its hospitals near the World Trade Center and Pentagon. Thompson also authorized the first-ever emergency use of the two-year-old National Pharmaceutical Stockpile, which delivered substantial medical supplies to the disaster sites.

The Centers for Disease Control (CDC) released one of its eight pre-packaged "12-Hour Push Packages," which contain medicines, intravenous supplies, airway supplies, emergency medications, bandages, and dressings. Each "package" comprises "several truckloads of materials."

In addition, the CDC provided 84,000 bags of intravenous fluid and other intravenous supplies, 350 portable ventilators, and 250 stationary ventilators. The Falls Church, Virginia-based American Red Cross Disaster Operations Center went on national alert and dispatched hundreds of disaster specialists to the scenes.

During a news conference the day after the attack, Thompson said, "It is now our mission to begin healing from this tragedy. From the moment we learned of these attacks, the Department of Health and Human Services began readying teams and resources to be sent to New York City and the Washington area to meet any needs of state and local officials. In short, we're making the full force of the Department of Health and Human Services, both as resources and medical expertise, available to the areas that need our assistance."

Thousands Treated

New York doctors and hospitals treated thousands of burned, broken, and crushed patients after the attack. Medical officials established temporary emergency rooms and triage centers and asked volunteers to help treat patients.

At hospitals in lower Manhattan, hundreds of doctors and nurses treated the wounded at the front lines of this new kind of war. Emergency rooms at several Manhattan hospitals filled with patients and medical staff, while hospitals in surrounding areas remained on standby.

New York University Downtown and St. Vincent's hospitals received most of the patients. Dozens of wounded people arrived sporadically after the attack. By late afternoon, 300 patients had arrived at St. Vincent's. Doctors treated patients for burns, broken bones, concussions, smoke inhalation, and eye injuries.

At Bellevue Hospital, doctors had treated about 125 patients by late afternoon, including between 30 and 40 with serious injuries. NYU Downtown had treated about 300 patients. In addition, emergency staff sent about 1,500 patients by boat across the Hudson River to tents and ambulances on the New Jersey shore.

National Public Radio (NPR) reported that an outdoor triage center was established just north of the World Trade Center, where doctors, nurses, police officers, and firefighters all helped with relief. Even film companies pitched in, providing lighting after the sun went down.

New York City Mayor Rudy Giuliani said by mid-afternoon that about 2,100 had suffered injuries in the World Trade Center attack, with about 600 taken to local hospitals. NPR reported approximately 1,100 patients were treated at city hospitals during the night. Giuliani also said some of the "walking wounded" returned to their communities in New Jersey and Long Island to receive treatment. In a CNN newscast on location, a visibly shaken Giuliani said, "The number of casualties will be more than any of us can bear ultimately."

According to various news reports, hospital officials said they had received only those patients injured outside the World Trade Center. They fully expected the number of patients to rise "dramatically" after rescue teams began "digging into the rubble."

At the Pentagon, patients poured into hospitals, while emergency teams treated patients outside the military facility.

Blood Supply "Adequate"

As thousands of Americans donated blood nationwide, both the American Red Cross and America's Blood Centers said blood supplies were "adequate to meet the immediate demand" in the wake of the attacks.

Red Cross spokesperson Chris Thomas was quoted in *USA Today* as saying, "We're mobilizing to be open 24 hours a day, and we're shipping blood to New York and Washington." He continued, "We have 80,000 units in inventory and we will commit to meet any need anywhere."

Red Cross Vice President Dr. Jerry Squires added, "We're working with the military in New York and New Jersey so we can get the blood in the appropriate hospitals." Dr. Robert Jones, CEO and president of the New York Blood Center, said the demand for blood in New York was "less than originally feared." Noting blood donation lines stretched along city blocks, he said, "We have had a remarkable response to donate blood. We have pretty much maxed out the ability of the city to collect blood right now."

Around the nation, long lines developed at blood donor stations. Some lines were so long people were asked to return the next day. Nationwide, it was the biggest outpouring of blood donors since the Persian Gulf War in 1991. Over 3,200 pints of blood were shipped from donation centers across the country to New York City and Washington, DC. Red Cross President Bernadine Healy told reporters, "We have an obligation … to continue to maintain our blood supply and keep inventories up."

USA Today reported the Red Cross has decided to donate up to 30,000 units to hospitals treating victims of the attack. Healy added the blood drives help people "console" each other. "This is wounded America. This is the spirit of giving. We don't want to turn that off."

The *New York Times* reported many donors are "acting out of compassion" as well as satisfying their felt need to do something. Steve Benson, a carpenter from Flagler, Colorado, said, "Giving blood is the only thing I can do at the moment because there are people in need in my country."

To schedule a blood donation, call 1-800 GIVE LIFE. To make a financial contribution to the Red Cross, call 1-800 HELP NOW.

Insurers Remove Restrictions

Several health plans with consumers in the New York and Washington, DC regions have suspended their restrictions on care following the September 11 attacks. Injured members of Cigna Insurance, for example, do not need to obtain prior authorization for hospital care in the two cities. Aetna Inc. and Oxford Health Plans have also said consumers injured in the attacks should not worry about authorizations or referrals. "This is an emergency situation, and we expect our members to go directly to seek emergency medical care, and we expect them not to worry about referrals," Aetna spokesperson Dave Carter told the *Houston Chronicle*. Aetna added staff and extended hours in four of its service centers in order to process benefit payments more quickly.

Empire BlueCross BlueShield, headquartered in the World Trade Center, established temporary command centers at its New York offices in

FINEST HOURS continued on page 14

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State Legislative Update

A monthly review of state legislative activity

COMPILED AND EDITED BY CONRAD F. MEIER

CALIFORNIA

HMOs are leaving rural California, and residents are being forced to pay higher premiums or go without coverage. At least 16 rural counties have lost some or all of their health maintenance organizations. Legislators have been warned by the HMOs, who say there are not enough patients able to afford rising health costs.

GEORGIA

Seeking to rein in spiraling prescription drug costs, the state has passed a get-tough measure aimed at collecting millions of dollars lost annually in improper Medicaid pharmacy claims.

In 1999, Georgia paid out some $21 million to cover prescription drug costs for Medicaid patients who should have had part of their bills covered by a third party, typically a private insurance company or the federal government.

ILLINOIS

Illinois became the 36th state to approve a new insurance producer licensing bill that brings the state into compliance with the federal Gramm-Leach-Bliley Act. H.B.2994 was signed in September by Governor George Ryan and becomes effective January 1, 2002.

The bill essentially adopts provisions of the National Association of Insurance Commissioners' model law allowing for reciprocity in the licensing of most nonresident agents.

INDIANA

State pharmacists won a temporary injunction to stop an "emergency" reduction in Medicaid reimbursements for prescriptions.

The lawsuit stems from Governor Frank O'Bannon's plan to cut nearly $100 million from the state Medicaid program's $1.15 billion drug budget by cutting the fee pharmacists get to fill a Medicaid prescription from $4 to $3, and by cutting drug markups by as much as one-half.

The two pharmacies involved in the suit, Walgreen's and CVS, say if the cuts take place, store closings and reduced hours would be necessary—affecting more than 650,000 Medicaid beneficiaries, as well as patrons who shop in stores that fill a lot of Medicaid prescriptions.

MASSACHUSETTS

The House Ways and Means Committee has approved a measure allocating $42 million of the state's FY 2001 budget surplus to increased Medicaid reimbursements for hospitals and grants to "financially distressed" hospitals. The measure is part of a larger $494 million surplus spending bill.

According to a statement made by Craig Melin, past chairman of the Massachusetts Hospital Association, to the *Springfield Union-News*, this "sets the stage" for reducing the annual $200 million gap between hospital Medicaid costs and state reimbursement rates.

"The problem," Melin stated, "is the gap is so large that it is affecting care all over the state." Passage by the legislature is expected.

MISSOURI

Thousands of disabled people will be able to earn more money and still qualify for Medicaid benefits under a new bill signed by Governor Bob Holden. Under the law, an individual can earn 2-1/2 times the federal poverty level and still qualify.

Holden called the legislature back into special session on September 5 in an effort to produce a new prescription drug program for seniors. The current program is breaking the budget. Senator Marv Singleton (R) has offered a bill that utilizes the private sector; it may run into stiff opposition from Democrats.

NEW YORK

Although state legislators have focused a great deal of their attention and efforts on providing health insurance for uninsured children, the majority of uninsured New Yorkers are adults, according to a study released last month by the United Hospital Fund.

Approximately 2.4 million of the estimated 3 million uninsured New Yorkers are between the ages of 19 and 64, and 75 percent of those are from families in which at least one member is employed.

The report notes New York has made "considerable progress" in addressing the uninsured children problem, but the uninsured rate for adults has remained high. Overall, 20 percent of the state's 9 million workers lack health insurance.

OHIO

Ohio's largest physicians association will stay on the sidelines, at least for now, in court challenges to far-reaching patient privacy regulations being enacted by the Bush administration.

Lawsuits challenging the constitutionality of privacy rules mandated by the Health Insurance Portability and Accountability Act (HIPAA) have been filed by doctors organizations in the past month in federal courts in Texas and South Carolina. (See story, page 11.)

KENTUCKY

Patients of county-owned hospitals may sue and recover damages for negligence if the hospital has liability insurance, the Kentucky Supreme Court ruled in August.

In a unanimous ruling that lifted the immunity that previously shielded such hospitals from lawsuits, the Supreme Court found the patients may collect damages from the insurer. The ruling is unclear as to what happens if no liability insurance exists.

PENNSYLVANIA

State legislators are crafting a plan to use a portion of the state's $11 billion share of the national tobacco settlement to provide basic health insurance coverage to about 375,000 uninsured adults. About 1.2 million state residents are reportedly uninsured.

The program will be managed by Patricia Stromberg, executive director of the state's CHIP program, and will be available to adults aged 19 to 64 years old who have been without health insurance for at least 90 days and who have lived in the state for at least 90 days. Eligibility is also means-tested, using 200 percent of the federal poverty level as a base.

The state Insurance Department is seeking proposals from private insurers.

RHODE ISLAND

Rhode Island ranks third in the nation in the percentage of children who have received the recommended vaccinations by age 2, and first in the nation in the percentage of children with health insurance. Legislators suggest it's a laudable record . . . but not a perfect one. A glance at the raw numbers shows the room for improvement.

TEXAS

The Young Conservatives of Texas (YCT) have drawn a line in the sand. Now they are challenging Bexar County District Attorney Susan Reed to step across it and join their side of a controversial health care issue involving the free, non-emergency treatment of illegal immigrants.

The 21-year-old YCT has filed a complaint with Reed's office, as well as with the district attorneys' offices in Dallas and El Paso counties. In those complaints, the group charges the hospital districts with dispensing "illegal socialized medicine." (See related story on page 12.)

WYOMING

The Wyoming health care subcommittee approved a prescription medication plan with a $1,000 deductible for any family earning less than 200 percent of the federal poverty level, or about $35,000 a year. After a three-month phase in, the deductible would drop to $300 with beneficiaries having a $10.00 co-pay. The program would be run by the state Department of Health. The bill now moves to the Labor Committee for further consideration.

Sources: The Council for Affordable Health Insurance (CAHI) and its member companies provided information for this State Legislative Update. Contact CAHI at mail@cahi.org. Additional material was provided by The National Association of Health Underwriters (NAHU) http://nahu.org/government, http://bizjournals.com, http://stateline.org, and Nexis/Lexis research.

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High-Risk HIP Will Return to Tennessee

Governor plans overhaul of troubled TennCare program

BY CONRAD F. MEIER

On September 28, Tennessee Governor Don Sundquist unveiled plans to revamp the state's troubled TennCare program, replacing it with a high-risk pool for people with pre-existing medical conditions, a managed-care Medicaid program, and a premium support program for the working poor.

"TennCare in its present form costs more than we can afford. It has more enrollees than we can pay for, and it covers more benefits than we can support," Sundquist said in a speech aired by Tennessee's public television stations and radio.

Sundquist proposes to divide TennCare into three parts beginning January 1, 2003:

- TennCare Standard, a traditional HMO for adults under the federal poverty level, children under 200 percent of the poverty level, and those deemed uninsurable by state underwriters.
- TennCare Medicaid, to serve the 820,000-plus Tennesseans who are Medicaid-eligible.
- TennCare Assist, a subsidy program to help low-income families buy employer-sponsored health insurance.

Some Become Ineligible

The changes, which require federal approval, mean at least 180,000 TennCare recipients could be eliminated from state-sponsored health coverage altogether. The level of state funding will determine benefit levels and the number of people to be served.

> **"Of the 180,000 people likely to become ineligible for TennCare, about 135,000 are adults who earn more than the federal poverty level . . . or who don't meet the state's current definition of uninsurability."**

"I know closing TennCare enrollment to non-Medicaid eligibles will impose hardships on some people in our state," Sundquist said in his speech. "I know some people who are eligible for benefits today will not be eligible in the future. None of this will be easy. But all of these actions are necessary if we are to preserve TennCare and provide health care for our children and citizens who can't get it otherwise."

Just hours after Sundquist's speech aired, a federal judge in Nashville issued a temporary restraining order to block the enrollment cutoff. Most of the other changes proposed by Sundquist were not affected by U.S. District Judge William J. Haynes Jr.'s order. A full hearing will be scheduled by mid-October.

Sundquist plans to submit his TennCare revamp to the Centers for Medicare and Medicaid Services (CMS) by December 15. Approval appears likely, as the Bush administration has said its goal for Medicaid reform is to give states increasing flexibility regarding how the program is run. (See "New Medicaid Reform Empowers States," *Health Care News*, September 2001.)

Budget-Buster

Launched by Gov. Ned McWherter in 1994, the TennCare single-payer experiment converted the state's entire Medicaid program to managed care and expanded it to cover uninsurables and some uninsured, drawing generous federal matching funds to pay for it. In his September speech, Sundquist noted the $5.6 billion program has lowered the number of uninsured in the state, increased immunizations, lowered infant mortality, and improved preventive health care.

Sundquist's revamp responds to major criticisms of the program: It covers too many people, offers benefits that are too rich, costs too much, and is draining the state budget. A legislative proposal to establish the state's first income tax in order to fund TennCare provoked angry protests at the State Capitol in mid-July. (See "Tennessee Taxpayers Revolt," *Health Care News*, August 2001.)

TennCare's advocates say the governor's revamp proposal will most hurt the state's elderly, disabled, mentally ill, and those in rural areas. Chad Miller, state director for AARP (formerly know as the American Association of Retired Persons), noted the governor's plan "will stop the flow of hundreds of millions of health care dollars from Washington to Tennessee. These proposals will not save the state money. In fact, huge new financial burdens will be placed on local governments faced with providing health care for those shut out of TennCare."

But the demographics don't agree with activists' claims: Of the 180,000 people likely to become ineligible for TennCare, about 135,000 are adults who earn more than the federal poverty level ($14,630 for a family of three) or who don't meet the state's current definition of uninsurability.

About 4,000 children would lose coverage under Sundquist's plan, but they are children in families whose incomes are above 200 percent of the poverty level.

Sundquist's plan assumes federal regulators at CMS and the Office of Management and Budget will give Tennessee the same generous federal matching funds for the new program that it gave to TennCare in 1992. Sundquist said he projects a modest total savings of $1.5 billion in state funds over the next 10 years, and $3.5 billion in federal funds over the same period.

Looking for an outstanding speaker?

Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

"Don't miss an opportunity to hear Merrill Matthews speak. He's knowledgeable, thoughtful, articulate,usually right, and always entertaining."

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New Jersey Adopts Patients' Bill of Rights

BY DANIEL BEERS

More than 3 million New Jersey residents enrolled in state-regulated health plans now have the right to sue their HMOs, under provisions of the so-called patients' bill of rights signed by Acting Gov. Donald T. DiFrancesco on July 30, 2001.

New Jersey is the ninth state to enact such a law, formally known as the Health Care Accountability Act. It is separate from the federal patients' bill of rights currently being considered by Congress.

The state law grants New Jersey residents covered by state-regulated health plans the right to sue if their insurers' decisions to deny or delay medical treatment result in serious physical or mental harm.

The new legislation does not apply to the 2.7 million New Jersey residents insured by employer-provided plans, which are regulated by the federal government.

The bill was strongly opposed by the New Jersey Association of Health Plans, which argued New Jersey already had a binding appeals process that it said significantly reduced the need for the ability to sue.

The New Jersey patients' rights bill is more strict than some versions of the federal bill, says Kevin Israel, an aide to Assemblyman Steven Corodemus (R-Monmouth County), who cosponsored the legislation.

The New Jersey law creates a two-tiered system for resolving complaints. The most serious

> **"More than 3 million New Jersey residents enrolled in state-regulated health plans now have the right to sue their HMOs . . ."**

claims, asserting an HMO's decision to delay or deny care resulted or could result in "serious or significant" harm, such as death or paralysis, go straight to court.

Daniel Beers writes for Insure.com The Consumer Guide.

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HIPAA and the Criminalization of American Medicine

BY GRACE-MARIE TURNER

Waste, fraud, and abuse in Medicare are serious problems … but so are the federal government's efforts to combat them.

Of course, egregious cases of fraud take place, and those engaged in criminal activities should be stopped and prosecuted. But the big dragnet for "health care criminals" is catching innocent doctors as well, creating an unhealthy climate of fear and defensiveness that hurts the medical profession badly.

An examination of the current controversy over waste, fraud, and abuse in the health care system reveals an enforcement system as troublesome as the problems it's intended to correct.

Criminalizing Health Care

In its zeal to rid the nation's health care system of waste, fraud, and abuse, Congress has passed a blizzard of new federal criminal statutes targeting the health care industry, including those contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The statutes are being enforced by hundreds of federal agents armed with hundreds of millions of dollars in investigatory funds. This new army of law enforcement agents is sweeping through hospitals and doctors' offices throughout the country to investigate a new class of "health care offenders."

Mark L. Bennett Jr., a Topeka, Kansas, attorney with the firm of Bennett & Dillon, LLP, says health care has become the prosecution of choice for many U.S. attorneys.

"At one point, drugs and drug offenders got the most attention from the authorities, then it was banking and savings and loan violations. Now … one of the prosecutions of choice is fraud relating to the provision of medical services." The reason, Bennett observes: "That's where the money is."

Arbitrary and Excessive

The federal government is using the threat of prosecution to collect excessive settlements from doctors "guilty" of clerical errors. Federal officials have developed a "system" to identify which doctors and hospitals might be subject to fines. Any billing practice that establishes a physician as a financial outlier on a computer statistical analysis can lead to a payment audit. The audit may look at a fraction of the doctor's medical records, identify a percentage that have coding or billing errors, then extrapolate fines to the whole practice based on the sample. The fines can be as high as three times the amount of the error.

Many of the nation's 650,000 physicians fear they could face armed federal agents, prosecution, and even jail time. "Demonizing the entire medical community with the broad brush of 'fraud, waste, and abuse' trivializes real fraud and sets up an adversarial tension in every patient-physician encounter," according to Nancy Dickey, MD, former president of the American Medical Association.

Federal prosecutions for fraud are at an all-time high. The current backlog began building when enforcement agents started levying much larger penalties than in the past.

Nursing home operators who violate patient health and safety rules, for example, have felt the crunch. The old penalties were generally $100 and were routinely paid, not challenged. But under the more aggressive policies, fines range as high as $10,000 for each day a home is out of compliance, with some penalties reaching more than $600,000.

Too Complex to Comply

Federal health care regulations now take up over 132,000 pages of regulation. Medicare alone accounts for more than 111,000 pages. The General Accounting Office acknowledged in a 1998 letter to House Budget Chairman John Kasich that Medicare's "size, complexity, and rapid growth make it an attractive target for fraud and abuse." The rules can be inconsistent and contradictory; it is virtually impossible for the average doctor to have a working knowledge of the mountain of regulation.

> **"Disagreements over medical necessity or clerical errors do not constitute fraud, and neither law nor regulation should effectively 'criminalize' the practice of American medicine."**

Legislating in the Dark

Instead of leading on the issue of health policy, members of Congress follow uninformed popular opinion. Congressional policy toward health care fraud and abuse has been fueled by political polls, which were in turn fueled by misinformation and a crude political expediency.

Rather than tackle the tough problems of structural reform of Medicare, politicians reacted to national polling data showing the majority of Americans erroneously believe high health care costs are almost exclusively the result of fraud and abuse.

The energy and discipline of the marketplace must be injected into this cumbersome, antiquated, centrally managed Medicare system to save it from bankruptcy. Federal agents chasing harried doctors is not a solution.

Disagreements over medical necessity or clerical errors do not constitute fraud, and neither law nor regulation should effectively "criminalize" the practice of American medicine. Congress and the administration should work to stop this trend before it does further damage to what has, until now, been the best health care system in the world.

Most importantly, Congress should take bold steps to restructure the Medicare system, and the health care system in general, to minimize opportunities for fraud.

Excerpted from a paper presented by Grace-Marie Turner, president of The Galen Institute and a contributing editor to Health Care News, *at a July 31 Cato Institute conference, "Making a Federal Case out of Health Care: Five Years of HIPAA." The full text of Turner's paper is available on the Internet at http://www.galen.org/news/080201.html.*

Fraud and Abuse Cases and Collections

	Judgments, settlements, fines	Criminal indictments filed	Convictions	Civil cases pending	Civil cases filed	Exclusions from Medicare/Medicaid
1997	$1.2 billion	282	363	4,010	89	+1,000
1998	$480 million	322	326	3,471	107	3,021
1999	$524 million	371	396	2,278	91	2,976
2000	$1.2 billion	457	467	1,995	233	3,350

Source: Department of Health and Human Services and Department of Justice, Health Care Fraud and Abuse Control Program, Annual Reports for FY 1997, 1998, 1999, 2000.

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Doctors Group Sues to Stop HIPAA Privacy Regulations

Two lawsuits challenge constitutionality of Clinton-era rules

BY CONRAD F. MEIER

On July 31, the Association of American Physicians and Surgeons (AAPS) announced it had filed suit against the U.S. Department of Health and Human Services to halt implementation of new medical privacy regulations.

The AAPS lawsuit challenges the constitutionality of the regulations based on their content and likely outcomes. The suit further claims the regulations violate the Paperwork Reduction Act.

For more information…

WWW The full text of the AAPS lawsuit is available in Microsoft Word at the group's Web site at **http://www.aapsonline.org/aaps/judicial/apscomplaint.doc**. Or use The Heartland Institute's *PolicyBot* online research service to request the document in Adobe Acrobat's PDF format. Go to **www.heartland.org** and search the *PolicyBot* database for document #**3266801**.

Kathryn Serkes, public affairs counsel for AAPS, can be reached by email at **kaserkes@worldnet.att.net**.

Specifically, the lawsuit contends the regulations:

- violate the Fourth Amendment, because they require physicians to allow government access to personal medical records without a warrant and authorize the government to develop a centralized database of personal medical records with personal health identifiers;
- are unconstitutional to the extent they govern purely intrastate activities by physicians using and maintaining medical records for patients, and disrupt state laws;
- violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and lack statutory authorization to the extent they regulate medical records other than electronic transmissions; and
- violate the Paperwork Reduction Act and Paperwork Flexibility Act and are unenforceable and incomplete.

Kathryn Serkes, public affairs counsel for AAPS, explained at a news conference at the Cato Institute in Washington, DC, "Physicians swear to do no harm. It's time we held politicians to the same standard." She labeled "heavy-handed" the unprecedented government access to private medical records that is provided for by the new rules.

"While masquerading as patient protection, the rules would actually eliminate any last shred of patient confidentiality," she said. "When it comes to government prying, these rules obliterate any remote notion of patients' rights."

She noted the rules require doctors to disclose all patient records—including handwritten notes and psychiatric records—to thousands of federal government bureaucrats … regardless of whether a patient consents to that disclosure.

Moreover, "law enforcement agencies will have unrestricted access to all records—including notes about drug use, family interactions, and other confessions."

Serkes warned, "Doctors can not only be fined for withholding records, but the feds can order them to refuse treatment to patients who won't consent to government disclosure.

"If patients expect the government to protect them from marketing efforts, they're in for a rude surprise. It was government employees who sold patients' medical records from government databases to HMO recruiters in Maryland a few years ago."

> **"While masquerading as patient protection, the rules would actually eliminate any last shred of patient confidentiality."**
>
> **KATHRYN SERKES**
> **PUBLIC AFFAIRS COUNSEL**
> **ASSOCIATION OF**
> **AMERICAN PHYSICIANS AND SURGEONS**

Serkes cited a survey of physicians that found "a whopping 96 percent of doctors" worry the proposed rules will compromise patient privacy.

"While some of the rule's specifics could be ironed out down the road, no amount of fine-tuning can fix a flawed approach," said Serkes. "Only a fresh start will head off irreparable damage to patients and their trust in the system."

AAPS is a national association of physicians founded in 1943 to protect the sanctity of the patient-physician relationship from intrusion of third parties. The organization is dues-supported and accepts no government funds. It notes no for-profit entities have helped fund its litigation.

Second Lawsuit Filed

The new privacy regulations have also come under fire from the South Carolina Medical Association (SCMA), which has filed its own lawsuit against HHS. The physicians' group contends the privacy regulations represent an unconstitutional delegation of Congress' legislative authority because they were drafted "with little congressional input."

The association, which represents 6,000 physicians, says the privacy rules are burdensome and will increase costs, "create more paperwork, and impede hospital pre-admission procedures."

SCMA President J. Capers Hiott told the *Washington Post*, "What we are filing is based on a constitutional flaw. We're not filing this because we are against anything that has to do with patient privacy. Physicians are one of the staunch supporters of patient privacy."

By filing the lawsuit, SCMA hopes to prevent the rules from taking effect and to "send them back to Congress" so new rules can be drafted with input from health care providers.

HHS spokespersons would not comment on either lawsuit when called by *Health Care News*.

The new privacy rules, required under HIPAA, were first issued by the Clinton administration. The Bush administration took no action to prevent them from taking effect in April.

AAPS successfully sued the Clinton administration several years ago to force disclosure of hundred of thousands of pages of secret documents from the President's Health Care Task Force. The decision in *AAPS vs. Hillary Clinton* was issued in August 1999.

"Individual Identifier" Controversy Resurfaces

Critics warn number could result in denial of care, privacy invasion

BY CONRAD F. MEIER

Eight years after then-President Bill Clinton failed in his attempt to put the federal government in charge of all matters health care, critics of the scheme are still doing battle with it, piece by piece. The latest feature of the plan making its way into law: the health care "identifier number."

The identifier is a crucial part of efforts to centralize all individual health care information into a government database. Congress authorized the creation of a personal identifying number for every man, woman, and child through a provision in the Health Insurance Portability and Accountability Act (HIPAA), passed in 1996.

HIPAA requires a unique health identifier be assigned to every living person, health care provider, employer, and health plan in an effort to assemble all health care transactions into a single database. Although federal legislators have to date denied funding for implementation of the individual identifier plan, Congressman Ron Paul (R-Texas) and several colleagues are concerned the identifier requirement remains on the books.

"We think it's an invasion of privacy, and we think it's a number that's going to be abused like the Social Security number has been," said Paul's spokesman, Jeff Deist, in a CNN interview.

Paul recently introduced a bill that would repeal those parts of HIPAA calling for identifying numbers. The measure would also prevent federal tax dollars from being used to construct or maintain a federal health care database. Paul says he fears a future Congress may wish to pass a national ID system.

Big Brother Wants to Track You

Congresswoman Nancy Pelosi (D-California) is getting ready to introduce a bill that would put the individual identifier system into practice. In a September "Dear Colleague" letter co-signed by Congressman Peter King (R-New York), Pelosi wrote, "Chronic disease is responsible for seven out of every ten deaths in the U.S. each year and costs our nation $325 billion in annual health care expenses and lost productivity. Despite these significant health risks, there is no national system that explores the relationship between chronic diseases and potentially associated environmental factors."

According to CNN News and other accounts, Pelosi's forthcoming bill would create a "national health tracking system" to collect, analyze, and report data on the rate of chronic disease and the presence of certain environmental factors. The bill would also "coordinate national, state, and local efforts to bolster our public health system's capacity to investigate and respond to" health risks.

Sue Blevins, president of the nonprofit Institute for Health Freedom, told CNN News she understands that good intentions are behind the measure. And she acknowledges a national database would improve access to information to treat patients in emergency situations.

"But," Blevins adds, "I still think it should be up to the individual to decide whether they want to be part of a government database." Like Paul, she fears that information in a centralized database would be wrongly accessed and used by computer hackers, profiteers, and would-be blackmailers.

Denial of Care

Blevins is also concerned health care could be denied to patients who refuse to disclose their number, much the way financial and other services are sometimes denied to people who do not disclose their Social Security numbers.

"HIPAA and the privacy rule codify the fact that a physician can refuse to treat you for not sharing your information," she said. "That's written into the privacy rule. That has not been a federal standard"… until now.

"Right now in the current Department of Health and Human Services appropriations bill, there's a proposal to penalize doctors and impose a $1.50 charge for every claim that's filed with the government that isn't processed electronically," Blevins added. "That's a way to move everybody into a national electronic system without mandating it."

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Uninsured Immigrants Burden U.S. Health Care System

BY STEVEN A CAMAROTA AND JAMES R. EDWARDS JR.

Managing Editor's note: The increase in the number of people without health insurance is one of the our most troubling social trends. An under-reported study from the Center for Immigration Studies finds the nation's health insurance crisis is being driven to a measurable degree by immigration policy.

The study, "Without Coverage: Immigration's Impact on the Size and Growth of the Population Lacking Health Insurance," was written by the Center's director of research, Steven A. Camarota, and James R. Edwards Jr. of the Hudson Institute. It offers detailed information, based on Census Bureau data, on immigrant and native insurance coverage at the national level, as well as for the major immigrant-receiving states and cities.

In 1998, 32.4 percent of persons living in immigrant households (primarily immigrants and their young children) lacked health insurance—more than twice the 13.9 percent of persons in native households.

Immigrants who arrived between 1994 and 1998 and their children accounted for an astonishing 59 percent of the growth in the size of the uninsured population—2.7 million people—since 1993.

The total uninsured population is one-third larger (44.3 million versus 32.7 million) when the 11.6 million persons in immigrant households without insurance are counted.

The debate over the growing number of uninsured in this country has failed to take into account the enormous impact of immigration on the nation's health insurance crisis. We cannot hope to contain health care costs or reduce the number of uninsured in the U.S. without addressing the role of immigration policy.

For more information…

WWW *contact Steven A. Camarota, director of research for the Center for Immigration Studies, at 202/466-8185. The complete text of the study Camarota coauthored with James R. Edwards Jr. can be found on the Internet at* ***http://www.cis.org/.***

A Difficult, Costly Problem

Immigration has made it much more difficult to reduce the size of the uninsured population. In just the last few years, for example, immigration has increased the number of uninsured children in the United States by more than 700,000, enough to offset most of the gains made so far under the new State Children's Health Insurance Program, enacted by Congress in 1997 at a cost of $4 billion a year.

Lack of insurance remains a severe problem even after immigrants have been in the country for many years. In 1998, 37 percent of immigrants who entered in the 1980s still had not acquired health insurance, and 27.2 percent of 1970s' immigrants were uninsured.

The lack of insurance is not solely a problem of *illegal* immigrants. Although a very high percentage do not have health insurance, illegal aliens comprise only an estimated 26.8 percent of the uninsured living in immigrant households.

The low rate of insurance coverage associated with immigrants is primarily explained by their lower levels of education and their higher poverty rates relative to natives. Because of the limited value of their labor in an economy that increasingly demands educated workers, many immigrants hold jobs that do not offer health insurance, and their low incomes make it very difficult for them to purchase insurance on their own.

"In 1998, 32.4 percent of persons living in immigrant households . . . lacked health insurance—more than twice the 13.9 percent of persons in native households."

The denial of benefits to some legal immigrants enacted as part of welfare reform in 1996 is not the reason so many persons in immigrant households are uninsured. Before welfare reform was enacted, nearly 31 percent of persons in immigrant households lacked health insurance, very similar to the current rate. Moreover, immigrant households continue to use Medicaid at higher rates than natives.

Policy Implications

By dramatically increasing the size of the uninsured population, immigration strains the resources of health care providers who provide services to the uninsured. Americans with insurance have to pay higher premiums as health care providers pass along some of the costs of treating the uninsured to paying customers. Taxpayers are also affected as federal, state, and local governments struggle to provide care to the growing ranks of the uninsured.

If current immigration policy remains in place, the Census Bureau estimates that 11 million new immigrants are likely to settle permanently in the United States in the next decade alone. The number of persons in immigrant households without health insurance could grow to 14 million.

If we are to deal effectively with the health insurance problem in this country, part of the solution must address immigration policy and expand access to health insurance to immigrants and their children already here.

UNINSURED continued from page 1

hold were uninsured, reported on a verification question that they were in fact insured. The contradiction is especially significant at higher income levels.

According to the National Center for Policy Analysis (NCPA), the verification question lowered the estimate of the number of uninsured living in households with annual incomes of $75,000 or more by 16 percent. The verification question lowered by 4 percent the number of uninsured living in households with incomes under $25,000.

The Census Bureau data may overestimate the rate of uninsurance among persons living in higher-income households because of a flaw in survey terms. The Census Bureau uses the term "household" to refer to all individuals living in the same residence, regardless of whether they are related. The Bureau considers all income of those in the household as "household income."

But "households" so defined can include a wide range of living arrangements: college roommates, multiple families, and adult relatives. Rarely do all members of such households have access to the total income of the household. This affects the ability to purchase health insurance. For example,

- A household with an income of $80,000 could consist of a two-income family with two children where each adult makes $40,000; or it could be a family of two wage-earners making $30,000 each and a related adult family member (perhaps a niece or nephew) making $20,000 who cannot be covered by the same health insurance because he or she is outside the immediate family.
- Three unrelated young adult roommates making $18,000 each would be listed as a "household" with income over $50,000, despite the fact that none can be a source of insurance for the others.
- Two families, each with an income of $40,000, sharing the same house, would be counted as a household with $80,000 in household income.

Overestimating the Uninsured

Notes NCPA, "The failure to account for these differences overestimates the rate of uninsured in the higher income levels and paints an inaccurate picture of the uninsured problem."

- The Census Bureau reported 8.3 percent of individuals in households with incomes over $75,000 were uninsured. However, when *families* at that income level, rather than households, are considered, the uninsured percentage falls to 6.8 percent.

"The Census Bureau . . . reports the uninsured problem may be less severe than previously thought."

- A family with two workers earning a total of $75,000 is less likely to be insured than a single individual making $75,000 because each only has access to $37,500 of that income. Thus, while 5.2 percent of workers earning $75,000 or more are uninsured, that number jumps to 9.7 percent for those earning between $25,000 and $49,999.

The NCPA analysis concludes, "When income is recalculated to exclude income of unrelated persons and related adult family members, the number of higher-income uninsured drops."

The results of a new CPS survey will be released this month.

For more information…

WWW see the report by Charles T. Nelson and Robert J. Mills, "The March CPS Health Insurance Verification Question And Its Effect On Estimates Of The Uninsured," August 2001, Housing and Household Economic Statistics Division, U.S. Bureau of the Census, available online at **http://www.census.gov/hhes/hlthins/verif.html**.

Additional information about the uninsured rate is available on the Web site of the National Center for Policy Analysis at **http://www.ncpa.org/pi/health/hedex6a.html**.

Also see "Census Bureau Reports May Overestimate Uninsured Rate in Higher Incomes Households," *BNA's Health Care Policy Report*, March 20, 2000 **www.bna.com**; Paul Fronstin and Rachel Christensen, "The Relationship Between Income and the Uninsured," *EBRI Notes*, March 2000, Employee Benefit Research Institute, 2121 K Street NW #600, Washington, DC 20037, 202/659-0670, **www.ebri.org/notesx/0300note.htm**.

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Litigate, or Regulate?

BY TOM MILLER

The managed care political debate was lost when free-market advocates failed to address the feelings of disempowerment held by individual consumers. A golden opportunity was missed, and fundamental reforms that would give individual consumers more control over their health care decisions remain unexplored political options.

On Capitol Hill, only two grim choices are presented: litigate, or regulate. Just about everyone's either prosecuting, or confessing to, the health insurance industry's political crimes and economic misdemeanors. What's left is mere plea bargaining over the sentence.

Expect a final "compromise" law that extends the tentacles of federal regulation more tightly over health insurance arrangements and health care delivery. This uncreative political destruction of employer-controlled managed care will clarify the ultimate choice ahead: between real consumer-driven health care and government-controlled medicine that remains private in name only.

Expanding Insurers' Liability

In the Senate, Democrats have been adamant about expanding liability for health insurers. They have refused to take "Yes, but" for a final answer. Even the "consensus" federal regulatory standards supported by Republicans carried the usual vague, undefined terms and weasel words that inevitably would expand bureaucratic discretion and federal micromanagement through future rounds of reinterpretation.

Bipartisan consensus also extended to guaranteeing independent external review of health plans' medical fact determinations in claims decisions. Again, both sides of the aisle initially signed on to the proposition that legislation should require "de novo" review. Under that standard, expert reviewers may consider, but won't be bound by, the terms of insurance plan contracts in determining what's medically necessary, experimental, or otherwise appropriate in medical coverage decisions.

A last-gasp Senate amendment belatedly tried to reclaim some of this surrendered ground, but it offered too little and came too late. Apart from a narrow exception for explicit benefits exclusions, the final Senate legislation still invites independent review panels to override the medical coverage standards of private health plans.

Saying that "only independent doctors should make health care decisions" really provides the pretext for the wholesale rewriting of private contracts to pay whatever a spare-no-expense medical community orders. The likely result will be a more expensive, centralized, and uniform standard of care, but neither a better one nor a more affordable one.

The costly strategic retreats by defenders of private health insurance did not even achieve their main political goal—heading off increased tort liability exposure by insurers and health plan administrators when patients are unhappy with coverage and treatment decisions under employer group plans. Crude efforts to limit remedies (pain and suffering recoveries, punitive damages) or restrict jurisdiction to less-plaintiff-friendly federal courts didn't make much headway in the Senate. They face equally steep odds in the House.

Defensive Measures Will Be Costly

Hard evidence for the likelihood of an exploding litigation lottery may be mixed, but it's beside the point. The real problem is that businessmen and insurers believe plaintiffs will win many cases and receive large damage awards from juries. Health plan administrators will overreact, by authorizing unnecessary care, to even the small possibility they may have to pay large penalties.

Corporate decision-makers fearing worst-case scenarios will adopt similar defensive behavior and consider cutting back their role in employer-sponsored insurance. Misperception becomes reality all too quickly. Like a retreating army, the Republican generals on Capitol Hill have given away a lot of market-based ground in order to defend a tort-free peninsula. While trading regulatory arms for damage-cap hostages, they remain reluctant at best to affirm that consumers should expect to get what they are promised in health plan documents and pay for—but neither more nor less.

Market Solutions Better

Congressional opponents of federal managed care regulation abandoned the high-ground theme of market-based consumer empowerment. Instead of offering consumers a new set of unreliable third-party guardians (regulators, independent medical reviewers, and courts), they should have emphasized greater tax equity for all health care purchasers, expanded pooling options outside the workplace, adequate disclosure, and prompt contract enforcement.

Disgruntled consumers then could choose and control the types of health plan and benefits packages for which they are willing to pay. Other deregulatory alternatives were ignored in the race to regulate. A policy environment friendlier to value-driven consumer choice would hold managed care insurers and self-insured employers more accountable to their true customers.

Consumers would rely on voluntary contracts and competitive markets, instead of random lawsuits, to stimulate better service, relevant disclosure, benefits flexibility, and health care innovation. They could hire and fire their own insurers. If we ask consumers to be more responsible for weighing the costs and benefits of their health-purchasing decisions, we still need to enforce the promises that health plan sponsors make to plan subscribers.

But the patients' bill of rights options on Capitol Hill blur the lines between tort and contract. Disputes over denials of coverage under employer-sponsored plans are matters of benefits administration, not medical malpractice. They are ill-suited for tort cases. However, the contract remedies available at the federal level under ERISA (the Employee Retirement Income Security Act) could be streamlined and improved. Adding early offer settlement incentives or adopting a worker's compensation-like schedule of recoveries tied to the cost of denied benefits are the better litigation-reducing options.

On the other hand, insurers and employers who still choose to more actively manage health care decisions or supervise in-network providers should be exposed to vicarious liability for medical malpractice and other negligent treatment decisions. Ideally, this tort liability would be an initial "default" setting. It need not even apply to most employers or even to the many insurers who offer "managed care light."

> **"[F]undamental reforms that would give individual consumers more control over their health care decisions remain unexplored political options."**

The respective parties to an insurance contract should be free to transfer or modify this liability for negligent medical treatment in subsequent rounds of bargaining.

Choice Is Key

Most of all, if the public is to accept after-the-fact results in health care, individuals must have before-the-fact opportunities to choose. Many consumers may not want to manage personally most details of their health care decisions, but they should get to decide who will decide for them. Public policy could make that goal easier, not more difficult, to accomplish by ending preferential tax treatment of third-party insurance arrangements and streamlining procedural mandates.

Later this year, Congress will cobble together compromise legislation, President Bush will declare a small victory against excessive punitive damages, everyone will smile at the bill-signing ceremony, and we will have moved another step backward by crippling market-based approaches to health insurance.

More employers will head for the exit doors or—more likely—shed perceived liability risks, bypass regulatory nitpicking, and transfer the risk of health cost volatility to employees.

When they resort to greater cost sharing, leaner benefits, and defined contribution-style options, the ultimate choices will become clearer for consumers. They can stay behind on the health care plantation managed by the new bosses—bureaucrats, lawyers, courts, and politicians—or take greater control over their health care through medical savings accounts, high-deductible insurance, individual insurance, and/or e-health-insurance alternatives. We won't have as many HMO scapegoats to kick around much longer.

Tom Miller is director of health policy studies at the Cato Institute. His email address is tmiller@cato.org.
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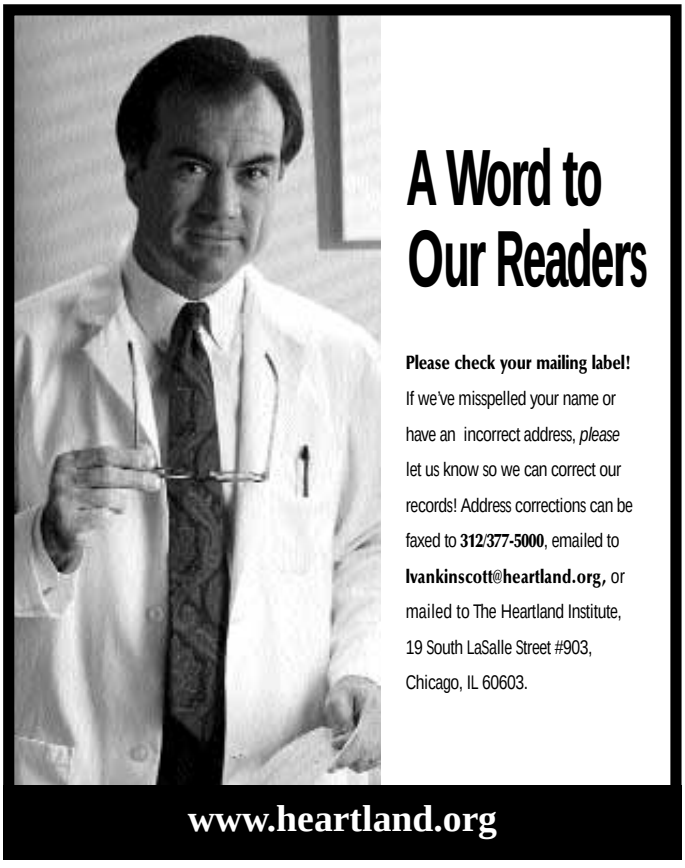
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INDIVIDUAL continued from page 1

health insurance as a way to attract better workers. The federal government allowed employer contributions to health insurance to be excluded from employees' income and payroll taxes, thus providing a tax break for employer-provided health insurance. That tax advantage was not available to the self-employed, or to individuals who purchased health insurance on their own.

The employer-based health insurance system brings many benefits, but also a number of problems…and the problems are growing as the economy continues its gradual transformation.

With an employer-based health insurance system, workers cannot control their own fate; they may find their coverage reduced, changed, or canceled through no fault of their own.

In addition, employers are increasingly, though perhaps reluctantly, concluding that health insurance is not worth the time and money. If Congress decides to increase employers' exposure to lawsuits, they may conclude providing health insurance just isn't worth the risk.

Fortunately, employer-based or government-run health insurance are not the only options available. We already have a working model that provides quality, affordability, and choice. The challenge is to expand that model so everyone can benefit from it.

> **"Today, in states that have kept health insurance regulations to a minimum, individuals and families are able to purchase good policies at reasonable prices."**

The Changing Workplace

While the employer-based health insurance system worked well in the Old Economy—that is, in an industrial economy where most people hold one job, usually some type of manufacturing position, for long periods of time—it simply does not meet the needs of an information-based New Economy, where people are increasingly becoming self-employed and/or work for several employers at one time, or in rapid succession.

A recent study by economists Robert Laubacher and Thomas Malone, both with the Sloan School of Management at the Massachusetts Institute of Technology, has outlined the changes that are reshaping the economy and the workforce. For example, according to the study:

- Today, more than 25 percent of American workers are part-time workers, independent contractors, or temps.
- When contract and on-call work is included, the share of the nation's workforce operating outside of traditional, full-time jobs grows to nearly 30 percent.
- In high-tech regions, these numbers can be significantly higher: only one-in-three employed Californians holds a permanent, full-time, day-shift job working on the site.

In explaining the trend in the workplace, Laubacher and Malone note the "traditional" U.S. employment system—in which firms hired entry-level workers, slotted them into clearly defined positions, trained then in-house, and promoted the best performers—defined most work in America from the end of World War II into the 1970s. Over the past quarter century, it began to unravel, driven by two major factors.

First, business competition became much more intense, due to globalization, deregulation, and the increasingly demanding institutional investors. Second, new information-driven ways of competing emerged—"lean" product development and manufacturing techniques, "re-engineering" of administrative work, outsourcing, and the granting of greater autonomy and authority to front-line workers. These changes altered the factors that determined success—where scale and stability had been crucial before, speed and flexibility were now favored.

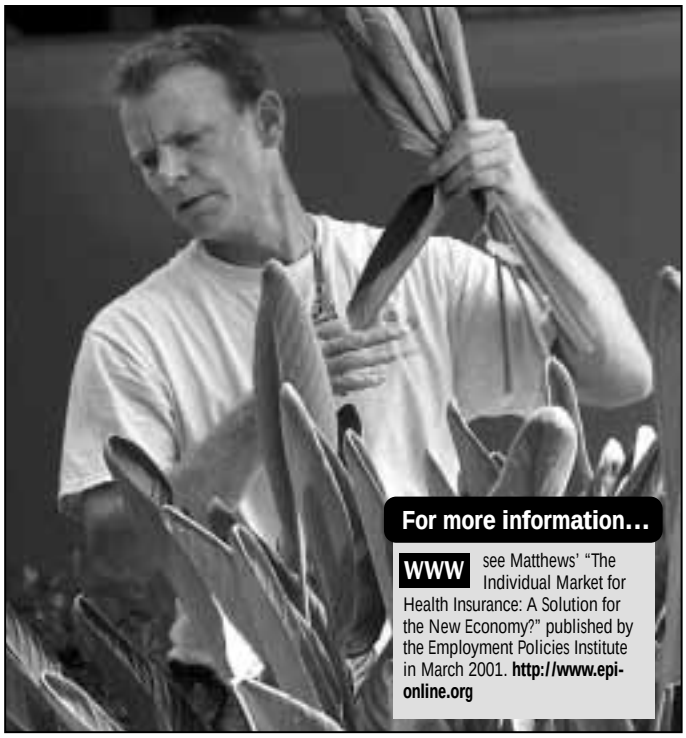
"Because of these developments," the authors write, "the old black-and-white classification, which defined the full-time 9-to-5 job as the norm and deemed everything else as 'non-standard'—is no longer an appropriate lens for viewing employment arrangements."

Not only is the workplace changing, but those who work are also in transition. For example, the number of married male workers fell from 86.1 million in 1970 to 77.6 million in 1998. By contrast, the number of married women in the workforce increased by about 50 percent, from 40.5 million in 1970 to 61.2 million in 1998.

New Insurance for a New Economy

What we need is a health insurance system that compliments a mobile workforce with a wide range of employer-employee relationships. One that may be connected with the workplace, but not necessarily dependent on it. One in which individuals, rather than employers, are in control.

The good news is we already have an effective health insurance model compatible with the changes being imposed by the gradual shift to a New Economy: the individual health insurance market.



For more information…

WWW see Matthews' "The Individual Market for Health Insurance: A Solution for the New Economy?" published by the Employment Policies Institute in March 2001. **http://www.epi-online.org**

Steve Anderson, owner of Anderson Landscaping & Maintenance Inc. in Orlando, provides health insurance to his employees, which costs him plenty. Individual insurance may be more appropriate for employers and employees in the new economy. *photo/AP*

For decades, people who did not get health insurance through their employer have turned to what is usually referred to as the individual market for health insurance—meaning it is individuals and their families, not employers, who purchase the policy.

Because consumers in this market spend their own money for health insurance, they want to make sure they get value for their dollar—a quest almost entirely absent in the employer-based health insurance model. Most want health insurance as a protection against expensive medical costs. As a result, they usually purchase high-deductible policies and pay for routine care out of pocket.

While employer-based coverage has been evolving significantly over the past 10 years, so has the individual market. Insurers have tried to develop policies that are comprehensive and competitively priced. Today, in states that have kept health insurance regulations to a minimum, individuals and families are able to purchase good policies at reasonable prices.

Who Buys Individual Policies?

Currently, the self-employed are the primary purchasers of individual policies. But many individuals whose employers do not provide health insurance also purchase these products.

In 1998, about 15.5 million people were covered by individually purchased policies:

- Half of those covered were workers;
- Only about 16 percent were nonworkers;
- The remaining 34 percent were dependents of those buying the policies.

The number of persons covered by individually purchased policies is admittedly small compared to the 155 million workers under age 65 and their dependents who receive health insurance through their employers. Nevertheless, that 10 percent of insured Americans are covered by individually purchased policies demonstrates there is an individual health insurance market with considerable experience meeting millions of Americans' health insurance needs.

Dr. Merrill Matthews Jr. is a visiting scholar with the Institute for Policy Innovation and policy director for the American Conservative Union Foundation. He is a senior fellow at The Heartland Institute and assistant editor for Health Care News.

FINEST HOURS continued from page 7

Albany, Staten Island, and Melville, according to Geoff Taylor, a spokesperson for the New York State Conference of Blue Cross and Blue Shield Plans. There were 1,800 Empire employees in the twin towers at the time of the attack.

Bloomberg reports the loss of Empire's office will "affect the company's processing of Medicare claims and the operation of its health plan for Medicare beneficiaries." However, a hotline operator at the Centers for Medicare and Medicaid Services said, "Empire processed about 55,000 claims [Tuesday] night, and we expect them to proceed under normal working conditions."

The United Network for Organ Sharing has delivered 24 organs since receiving air clearance on September 11, with deliveries coordinated by regional organ procurement organizations. Anne Paschke, a spokesperson for UNOS, said the four-to-six hour lifespan of hearts and lungs intended for transplant makes "quick delivery . . . especially crucial." For organs such as kidneys and pancreases, viable recipients are determined based more on "tissue-matching than need," and therefore those organs must usually travel longer distances.

The FAA cleared planes to fly for emergency medical purposes after blood centers were left seeking ways to ship vials of donor blood to testing sites. Accurate testing for HIV, hepatitis B, and other infectious diseases demands that the blood be tested within 72 hours of its being drawn.

Pharmaceutical Firms Take to the Road

Meanwhile, the country's pharmaceutical industry had not received FAA clearance, prompting firms to respond to the demand for drugs and supplies solely by ground transportation. Companies were trucking drugs ordinarily flown to distributors and hospitals to ensure products arrived where they were needed.

Mark Grayson, spokesperson for PhRMA, said, "There is an average 90-day supply of each drug in the U.S. and plans made in preparation for possible disruptions with the Year 2000 changeover are helping companies allocate those products." According to a report from Bloomberg News, representatives from Pfizer, the world's largest drug maker, said "the grounding of air traffic isn't expected to lead to shortages."

As the health care system met the incredible demand, the chaos of terrorism was replaced quickly with order and heroism.

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Politicians Delight in Killing Goose that Lays Golden Eggs

BY STUART A. WESBURY JR., PH.D.

Most adults in the U.S. can remember when doomsayers announced health care costs were about to destroy our nation's economy. Double-digit inflation in health-related expenditures would cripple local, state, and national budgets. Former Governor Richard Lamm of Colorado described health care as the Pac-man of his state budget, devouring enormous amounts of money and pushing other expenditures out.

At the same time, many employers had reached the point of no return. They were even considering dropping employee health insurance programs. Something had to happen.

That something was managed care. Over a 20-year period, managed care became the predominant form of health care insurance in the U.S. HMOs, PPOs, IPAs, and the like became well known. Managed care, in many forms, was firmly established. Health care services and health care insurance had been dramatically reformed.

Cost Spiral Slowed

But something else very important happened. The inexorable rise in health care costs had been dramatically slowed. Health care ceased to be the major driver in overall national inflation. Budgets seemed to breathe a sigh of relief, and money could be spent on priorities other than health care.

Somewhat lost in the euphoria was the reason behind the cost savings in health care: managed care. This is not a matter of opinion; it is a matter of fact. The goose of managed care had provided our nation with many cherished golden eggs.

The path to managed care was not, of course, paved only with golden eggs. Many health care providers saw their incomes fall. Hospitals merged to take advantage of economies of scale, often reducing workforces in the process. Patients no longer had direct access to specialists and expensive tests. Approvals had to be sought, physicians had less discretion, and concerns about denial of care surfaced.

Dangerous to Your Health?

"Red flags" were raised, as politicians and the press appeared to have exposed a downside to managed care. A cry went up to protect the people from the monster of managed care. The "Patients' Bill Of Rights" movement was launched.

But before we go too far down that road, it is essential that we determine if managed care is, in fact, a threat to your health.

In the August 1998 issue of the *Journal of Health Politics, Policy and Law*, Emanuel and Goldman explained, ". . . there are limited and inconclusive empirical data on the occurrence, extent, and consequences of conflicts of interest by omission" (the perceived incentive within managed care organizations to provide less care than is appropriate). Further, they noted, "Other studies show minimal or no compromise of patients' health."

An article in the January/February 2000 issue of *Health Affairs* appeared to concur. Authors Harris, Ripperger, and Horn examined legislative mandates that limited the ability of managed care plans to use specific techniques to manage costs. The researchers concluded, "Ironically, these techniques have yet to be proven to be detrimental to health plan members on a widespread basis."

My interpretation of these reports is that managed care provides appropriate care to patients, and sweeping negative allegations about the quality of care delivered are not justified.

There is another body of evidence that cannot be overlooked and may even be startling to those anxious to denigrate managed care. This evidence is found in the approval ratings managed care organizations receive from their patients.

The February 2001 issue of *Managed Care Executive* includes an article headlined, "HMOs Earn High Ratings from the Public." The story offers evidence that managed care ratings are remaining quite positive.

In a survey of Arizona state employees, a managed care organization was rated highest of six available choices for health insurance. Eighty-seven percent of state employees using managed care provider Cigna for their health care reported satisfaction with the service they received, versus 83 percent for the provider ranked second.

Effective this month, Cigna has been named the sole health care provider for State of Arizona employees. State employees will have a choice of three Cigna options; all meet the definition of managed care.

Anecdotes Make Bad Policy

If the vast majority of patients are satisfied with their managed care plans, and if no evidence exists in the research literature to show such plans deliver inappropriate care to their patients, why the attack on managed care?

In short, it's anecdotal evidence. Our elected officials are responding to isolated incidents—saddening, often angering incidents, but isolated nevertheless.

Before state and federal elected officials make the mistake of enacting bad public policy on the basis of anecdotal evidence, they ought to acquaint themselves with the surveys that document patient satisfaction with managed care, and the research literature that confirms the appropriateness of care delivered by managed care organizations.

> **"I like my managed care. Please politicians, do not make it cost more!"**

Every highway accident does not lead to a recall of automobiles. Every drug side effect does not remove the drug from the market. And, thank goodness, the FDA does not approve new drugs on anecdotal evidence. We must concentrate on the incredible success of managed care. Let us not forget that more laws and regulations will lead to higher health costs for Americans . . . and every increase in health care costs results in more uninsured Americans.

The Right to Sue

Though patient appeal and grievance processes are clearly spelled out in managed care contracts, elected officials seem especially concerned that patients do not have the explicit right to *sue* their managed care organizations. Proposals abound to lower barriers in the way of lawsuits for punitive damages.

My fervent hope is that all parties in this national debate will remember that the financial impact of such lawsuits falls squarely on insured citizens themselves. Every lawsuit and award increases the premium we pay for insurance. I fear that when our policymakers think of lawsuits and punitive damages, they believe the money to pay for them comes from fairies, guardian angels, or the pockets of managers and stockholders.

Conclusion

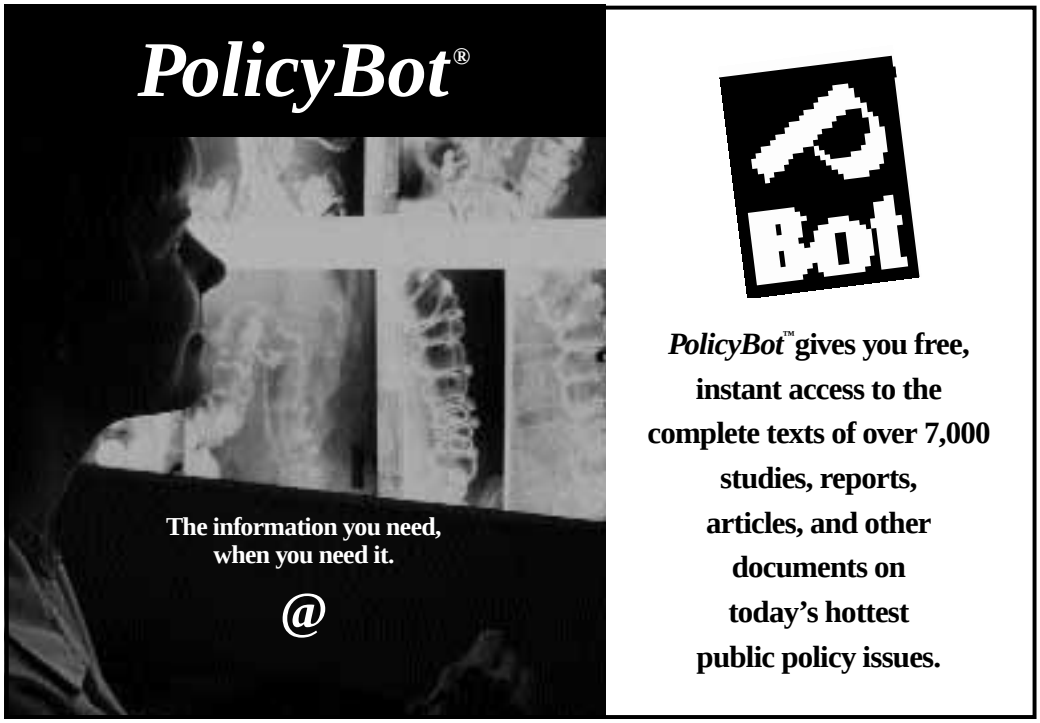
Rather than proposing "reforms" that can only increase the cost of health care, our elected officials should be seeking ways to encourage managed care to become more efficient and less costly.

There is much money to be saved in health care, to the benefit of all Americans. A General Motors official has said he believes 30 percent of all health care costs are simply waste. *This* is where government assistance is needed.

Research support and public statements of appreciation for the financial benefits created by managed care organizations should be the outcome of political discussions. The opinion of the vast majority of Americans enrolled in managed care should prevail in this debate.

I like my managed care. Please politicians, do not make it cost more!

Stuart A. Wesbury Jr., Ph.D. is professor emeritus in the School of Health Administration and Policy at Arizona State University's College of Business. With Joseph L. Bast and Richard C. Rue, Wesbury is the coauthor of Why We Spend Too Much on Health Care *(1993). His email address is stu.wesbury@asu.edu.*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THE GALEN REPORT

A monthly review of health policy matters

The magnitude of the losses for our country and the sadness, grief, and anger that all of us have experienced since September 11th's incomprehensible tragedy have been extraordinarily difficult to bear. But the loss is far greater for those who suffered personal losses of loved ones as well.

A dear friend and colleague, Gene Steuerle of the Urban Institute, lost his wife, Norma, on the plane that crashed into the Pentagon. Norma was a clinical psychologist who was active in her church and community. Born in Pittsburgh, she had been a valedictorian of her class at Carnegie Mellon University and held a master's degree from Temple University and a doctorate from the University of Wisconsin. Please keep Gene and daughters Lynne, 24, and Kristin, 28, in your prayers. We also pray for the many others of you who lost family members, friends, and colleagues in this catastrophic tragedy.

Those of us in Washington and New York experienced personal fear as the disasters were multiplying, not knowing if we would be next. Our offices at the Galen Institute are a few miles south of the Pentagon, and those outside our building heard the impact of the Pentagon crash. We felt we were in a state of siege.

As we all try to go forward, we share the pride in the uniting of our national spirit and patriotism, and we are heeding President Bush's request that we try to get on with our lives.

"Congress needs to act on certain targeted measures involving health care, particularly focusing on those who genuinely need help . . ."

What does this mean for the people's business? Political leaders have clearly responded to the higher calling for our country, pulling out of the swirl of partisan debate.

Certainly, the agenda has changed dramatically.

Does it sound at all reasonable in this new world for Congress to be consumed in a debate over spending $300 billion for a Medicare prescription drug benefit, especially one that would cover the wealthiest seniors, when our national defenses and intelligence capabilities so need to be strengthened?

In addition, I think and hope that the American people would be furious if they saw Congress now wasting its time on the seriously flawed, harmful patients' bill of rights.

Congress needs to act on certain targeted measures involving health care, particularly focusing on those who genuinely need help, like the uninsured and low-income seniors without prescription drug coverage. But political leaders also need to be concentrating on other initiatives that have not been at the top of the agenda before now.

For example, what initiatives do we need to put in place to encourage private companies to focus their considerable research capabilities on combating chemical and biological weapons and to redirect funds in the public sector to these areas?

Further, the nation must focus on developing a much stronger public health infrastructure to combat biological and chemical weapons. The nation's medical personnel and hospitals are ill-equipped to deal with potential casualties from these weapons. Already, Senator Ted Kennedy has signaled these deserve the federal government's utmost attention.

As we move forward, the states are likely to play a bigger role in the health debate than Washington, as will market-based solutions to health sector problems. We offer the following roundup of papers and articles, most of which were written before the terrorists' attack, but which still have relevance to the coming policy debate.

God Bless America!

Grace-Marie Turner

NEW PUBLICATIONS

Is Tax Reform the Cure for the Ailing Health Care System?

Grace-Marie Turner
IPI Insights, July/August 2001

President George W. Bush has made expansion of health coverage to the uninsured a top priority of his health reform agenda. A key element in that initiative is providing refundable tax credits to the uninsured to assist them in purchasing private health insurance.

The idea has support on both sides of the political aisle, but it often is rejected by experts in tax policy as adding yet another layer of complexity to the tax code.

In this excerpt of a chapter written for a forthcoming book on tax reform for the Institute for Policy Innovation, Grace-Marie Turner explains how tax credits can help rectify distortions in the financing of health insurance while setting a proper course for overall tax reform. Without action and public education, the current favored tax treatment of employment-based health insurance could well be the Achilles heel of tax reform.
http://www.galen.org/news/082301.html

Health Care Quality: Would It Survive a Single-Payer System?

Merrill Matthews Jr., Ph.D.
and Robert J. Cihak, M.D.
Washington Policy Center, July 2001 Policy Brief

Merrill Matthews and Robert Cihak, both contributors to *Health Care News*, examine the dangers of creating a single-payer health care system in Washington State. The study examines the meaning of health care quality and discusses the impact single-payer systems have on health care access, affordability, new technology, and patient satisfaction, as well as the role of physicians.

The study offers many examples of problems with single-payer systems abroad. For example, "The five-year survival rate for men with colon cancer is 41 percent in Great Britain, versus 64 percent in the U.S., in large part because of a lack of drugs routinely administered in the U.S."

The authors conclude that if policymakers move toward a single-payer health care system, "[T]hey will find that Washington citizens will be left with neither care nor quality."
http://washingtonpolicy.org/HealthCare/PBMatthewsCihakHealthCareQuality.html

Medical Savings Accounts Progress and Problems under HIPAA

Victoria Craig Bunce
Cato Institute Policy Analysis, August 8, 2001

In a new study published by the Cato Institute, Victoria Bunce writes, "The federal MSA program has been unnecessarily handicapped, if not permanently crippled, by HIPAA's unreasonable restrictions on the MSA demonstration project."

Bunce looks at the concept of MSAs, their history, and how they work in practice. She argues, for a "fairer test of MSAs Congress should peel away the remaining legislative and regulatory restrictions on federally qualified MSAs. Expanding the availability of tax-advantaged MSA plans with high-deductible insurance could allow many Americans to economize on insurance costs, save for future medical and long-term-care expenses, and still remain protected against the risks of catastrophic illness."
http://www.cato.org/pubs/pas/pa-411es.html

New Workforce Survey Reveals Expense Control Is Most Critical Business Challenge Facing Employers in 2001 and Beyond

Total Health Advocacy Partners,
Andersen, and CalPERS

The most critical business issue facing employers is expense control, specifically the rising cost of health care and disability and labor costs, finds a new Productive Workforce Survey.

The survey was administered in all 1,400 public agencies served by California Public Employee's Retirement Systems (CalPERS). Respondents indicated, "The most effective [cost containment] strategy has been to implement a health benefit defined contribution plan."
http://www.thap.net/news/prod_wf_survey_pr.html

The Galen Report *is a monthly review of health policy matters provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320. Grace-Marie Turner is president. The report is compiled by editor Elizabeth Turner, who can be contacted at 703/299-9550. Or visit The Galen Institute Web site at http://www.galen.org.*

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CHOICE continued from page 1

sponsored. That assumption must change if we are to meet the needs of America's uninsured."

Survey Highlights

- Respondents said the Patients' Bill of Rights would not make health insurance coverage more affordable, but they believe it would give them more choices and more freedom to sue their health plan.
- Sixty-three percent of respondents said their health insurance premiums had recently increased, and 6 percent had dropped their insurance because it was too expensive.
- When asked who to blame for the increases, 33 percent said doctors and hospitals charge too much, and 32 percent said insurance companies are inflating their profit margins. Only 16 percent said government rules and regulations were to blame, while 14 percent blamed pharmaceutical companies for increasing the price of drugs.
- Survey respondents were evenly divided on whether they would support replacing private health insurance with a government-run plan, even if taxes would increase.
- Sixty-four percent of respondents said they would not support requiring health insurance companies to support all Americans.
- Most respondents said their monthly health insurance premiums were between $100 and $400.

"When asked whether Congress should pass legislation giving them the right to sue their health care plans, or pass legislation creating a tax credit for health insurance, 79 percent of respondents said they would rather have a tax credit."

Freedom, Not Rights

"It was interesting that Americans view doctors, hospitals, and insurance companies as the culprits as insurance costs rise," said Jeff Smedsrud of Strategic Research Group.

"Many physicians tell us that they are feeling the pinch of rising costs and in reality, many of the insurance companies are actually losing money as they pass along cost increases, such as high prescription drugs. Furthermore, insurance companies have faced greater regulation over the past decade and yet it has not lowered costs to consumers."

"Regardless of who is at fault," said CA's Nelson, "it is clear from our survey that consumers do not see the Patients' Bill of Rights as the answer to rising health care costs and would rather see legislation that creates opportunities for some 40 million Americans who do not have health insurance."

And, Nelson said, "We believe—and the survey supports this belief—that the only real way to encourage more Americans to purchase health insurance is through tax credits or deductions for all individuals who purchase their own health insurance and to restore competition and choice in individual and small business health insurance markets.

"We also believe that it is time for the Congress to pass legislation that would expand state health safety nets or risk pools to help the medically uninsurable and develop ways to keep associations strong so they can continue to offer their individual members affordable health insurance. Such legislation would be a real Patients' Bill of Rights—one that really benefits consumers and keeps health costs down."

CA is a national, nonprofit, nonpartisan association that provides benefits and services for members in every state. Households from around the country were randomly surveyed for the report.

For more information…

WWW visit the Communicating for Agriculture and the Self-Employed at **http://ca.cainc.org**, or contact Wayne Nelson at 612/819-4629 or Jeff Smedsrud at 952/884-4258.

For more information on state-run high-risk health insurance pools, see **http://www.heartand.org/studies/meiersum.htm.**

"Surveys since 1973 consistently show that two-thirds of Americans think we spend too little on health care, while fewer than 10 percent think we spend too much."

Time to Cut Out the Middle Man

BY GREG SCANDLEN

During the last decade the health care industry, out of concern for growing health care costs, moved decisively away from traditional fee-for-service insurance to managed care. The rush was based on a fundamental misunderstanding of the causes of health care inflation.

The argument went that doctors were encouraged to perform unnecessary services because they were paid according to the number of services they delivered. The answer was to make physician compensation independent of the amount of service delivered, either by putting doctors on salary, or through using "capitation"—a per-patient payment that was blind to the amount of services delivered.

But fee-for-service wasn't what caused inflation; third-party payment was. Consider all of the services that are purchased on a fee-for-service basis: auto repair, accountant's services, barbering. None is subject to excessive inflation.

Third-Party Pay . . . for Haircuts?

One pays a fee for getting a haircut. That price may vary depending on the barber's overhead, the market segment he's targeting, etc. The mere fact that the barber is paid a *fee* does not mean he can charge an *excessive* fee, because you would take your business elsewhere. Nor does it mean he can force you to get your haircut weekly instead of monthly, even though he might want to. You would refuse to pay for needless visits.

Now consider how that would change if a third party was paying for your haircuts. You might go to the most expensive barber you could find, one that provided extras you valued: a shoulder massage, pleasant surroundings, interesting reading, a cup of cappuccino, or valet parking. And you would visit as often as you wanted.

The third party would look at the bill and say, "Geez, the price of haircuts has gone through the roof!" But, having agreed to pay a fee for the service, they would have little choice but to pay the bill.

Eventually, the third-party payer might decide to capitate the barber, paying him ten dollars per person per month. Suddenly, the dynamics have changed. The barber gets his ten bucks whether he cuts your hair or not. His incentive is to avoid cutting your hair. If you insist on getting a haircut, he certainly won't provide you with any extras. And, of course, all barbers would get paid the same—whether they are Hollywood stylists or recent graduates of a Marine Corps chop shop.

The Problem with Third Parties

Health care is more serious than haircuts, of course, but the underlying economics are the same. Fee-for-service is inflationary only when a third party is paying the bill. If the consumer pays directly, there is a reluctance to part with money, and that controls the cost.

This is true regardless of the kind of third-party payer involved—employer, insurer, or government. No third-party payer is willing to write a blank check. They will all find a way to limit their costs by restricting the supply of services available to the consumer.

They might limit the number of licensed providers, use waiting lists, ration the kinds of services available, deny service based on medical necessity, or prevent certain groups—such as the elderly—from receiving certain services—such as transplants.

Such rationing, of course, results in unhappy consumers. In the United States, we are experiencing a "managed care backlash," but people in other countries are not much happier. A survey of five English-speaking countries showed that, despite very different health care systems, the populations have remarkably similar levels of unhappiness with their systems.

Another consequence of third-party pay is that consumers have no idea what health care costs. The payers know, and employers, economists, and politicians are becoming alarmed that costs are rising by double digits again, but the American people are unaware and unconcerned. Surveys since 1973 consistently show that two-thirds of Americans think we spend too little on health care, while fewer than 10 percent think we spend too much.

Consumer-Driven Solution

As long as people are disconnected from the cost, as long as they think rising costs are someone else's problem, there will never be the national consensus needed to change the system.

That's why recent efforts to put more control of health care resources and responsibility in the hands of consumers are so important. The movement towards creating a "consumer-driven" health care system is taking many forms—medical savings accounts, defined contribution benefits, "premium support" or vouchers for Medicare, personal health accounts—but they all begin to merge the consumer and the payer, and reduce the role of third parties.

Ultimately, that's how we will create the answers that managed care failed to find.

Greg Scandlen is senior fellow in health policy at the National Center for Policy Analysis and contributing editor to Health Care News.

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My Turn

Improving Accountability in Congress

BY CONRAD F. MEIER

I must admit I had my doubts about George W. Bush leading the country as our new President. His opposition to the Kyoto Protocol and to the ergonomics rules began to give me some confidence in his leadership abilities.

But nothing comes close to his strong, disciplined leadership in the wake of the terrorist attack on our nation. He demonstrated his courage by putting the whole ugly issue before every American. He has told us this new war won't be easy, won't be quick, won't be cheap, and will, of necessity, sometimes be fought in secrecy. He has proven himself a leader up to the formidable task of marshaling all our human and material resources in defense of a free society.

There will be numerous tests for him and us in the long battle ahead. Today my doubts are gone. George W. deserves our confidence and complete support.

I hope we will learn some hard lessons here, not the least of which is that we can all get along much better if we understand just how fragile our liberties are. It would be prudent to protect them from enemies both foreign and domestic. We must remain steadfast in the belief our freedom is not free if we are subjected to all manner of troubling legislation set forth as "needed" in order to keep us a free and secure nation. We will not sustain freedom by taking it away in little pieces.

You might ask, what is the role of *Health Care News* in these times? None, some would say. My reaction is to follow the President's request to get back to work and show our resolve. As I see it, our work is the business of reporting health care news and analysis, and our resolve is in continuing the effort to preserve the values of independence and free markets in health care. Anything less and the terrorists win!

Medicaid Flexibility

Well before September 11—it seems like forever now—President Bush announced he would allow states greater flexibility in setting guidelines for Medicaid coverage. He said doing so would streamline an overly complex system, make it more responsive to local citizens, and save millions of dollars that could be used to expand coverage for uninsured lower-income Americans.

Bush's high regard for states' rights did not go down smoothly with those who seek to centralize control over social policy in the District of Columbia.

A hurricane of gloom-and-doom predictions erupted from Democrat representatives and senators home during the August break. Judging by their rhetoric, you might think Bush is the grinch who stole the entitlement Christmas tree.

The situation illustrates how our political system allows the worst type of demagoguery to flourish. As the *Wall Street Journal* recently editorialized, "In a democracy, the antidote to demagoguery is accountability. Unfortunately, that accountability has been undermined as contentious public issues have been moved from the legislative process—and the public debate that occasions—to back-room regulation. In doing so, Congress is let off the hook."

Democratic Congressmen, in other words, are free to denounce Bush initiatives in the most colorful of terms, but never have to *vote* against them or for a better alternative. Stated this way, a solution to the problem becomes apparent: Congress should be asked to vote for or against every regulation whose economic impact exceeds $100 million, and the vote should be made public.

Congressional Review Act

The good news is such a rule already exists. President Ronald Reagan issued an executive order requiring the Office of Management and Budget (OMB) to study the impact of all regulations before they could be approved. In addition to this, the 1996 Congressional Review Act (CRA) gave Congress a 60-day window during which to review any regulation.

> **"... our work is the business of reporting health care news and analysis, and our resolve is in continuing the effort to preserve the values of independence and free markets in health care."**

President Bill Clinton modified the order by shifting the balance of power from the OMB back to the agencies and limiting reviews to those rules and regulations with an impact of $100 million or more. According to a recent Competitive Enterprise Institute report, "10,000 Commandments: A Policymaker's Annual Snapshot of the Federal Regulatory State," there are 158 $100 million-plus regulations. Since its passage, the CRA has been invoked only once: over Clinton's ergonomic rules. Congress voted to revoke those rules months ago.

The flaw in these otherwise-sensible approaches to accountability—OMB review and CRA— is that the decision to use the rules is left up to Congress. Unless the President campaigns for Congress to act, this "fox and the hen house" arrangement gives Congress little incentive to do anything.

Case in Point

If the Health Insurance Portability and Accountability Act (HIPAA) had been put to the test of CRA, it seems to me the reasonable men and women of the U.S. Congress may well have concluded the bill's benefits were not worth its billion dollar price tag.

HIPAA contains so many regulations—guaranteed issue, guaranteed renewal, and medical privacy mandates—that it drives the cost of health insurance premiums well beyond the $100 million dollar threshold, by at least ten-fold. And that doesn't count the cost of consumers suing their HMOs, or the cost of implementing a "unique identifier" system for every man, woman, and child.

President Bush would do the American people a tremendous service by asking for a joint congressional resolution on every bill, thereby putting all members on record voting for or against real bills. The ratio of accountability to demagoguery would receive a much-needed boost.

This may not stop all manner of bad social policy, but it will provide for a more enlightened citizenry before legislation is passed. We'll be better voters, too, with more information before us when we exercise our right to vote the rascals out of office.

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Health Care News is a publication of The Heartland Institute, a nonprofit research organization based in Chicago, Illinois. For more information, visit our Web site at www.heartland.org, call us at 312/377-4000, or contact us by mail at 19 South LaSalle, Suite 903, Chicago, Illinois 60603.

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October 1, 2001

Dear Readers:

You may have noticed that recent issues of Health Care News didn't arrive at their usual monthly intervals. For that, we owe you an apology and an explanation.

A lack of funds meant the July issue was printed and mailed in August. The August issue was printed and mailed in mid-September, and the September issue was mailed late that month. Finally, the October issue–this issue–was printed in mid-October and you should have received it at the end of October.

Thank you for your patience and understanding. Summer months are the hardest times for fundraising, and this was our toughest summer ever, and we're not out of the woods yet. We still need your help.

A single issue of Health Care News costs $20,000 to write, print, and mail. Some of you offered to contribute toward the cost of your subscription or the subscriptions of others. Thank you, and we've modified the reply form below to allow you to do so. If you can afford to give more, won't you please consider doing so today? Thanks in advance for your help, and I hope to hear from you soon.

Sincerely,

Nikki Saret
Publisher

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_____ Doctors' rights advocate
_____ Patients' rights advocate
_____ Taxpayers' rights advocate
_____ Employers' rights advocate
_____ Other: Specify _____

____ MEDIA
_____ Health care reporter/writer
_____ Print
_____ Electronic
_____ Other
_____ Print
_____ Electronic

____ BUSINESS
_____ For-profit company
_____ Non-profit company
_____ Trade association
_____ Chamber of commerce or similar organization

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____HEALTH CARE PROFESSIONALS
Are you a:
_____ Doctor
_____ Nurse
_____ Insurance broker
_____ Pharmacist
_____ Hospital administrator
_____ Insurance industry professional
_____ Pharmaceutical industry professional
_____ Managed care professional
_____ Other: Specify _____

____ PUBLIC OFFICIALS
Were you:
_____ Elected
_____ Appointed

At what level of government:
_____ Federal
_____ State
_____ County or local

____ REFORM ACTIVISTS
Which best describes your role in the health care reform movement?
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_____ Patients' rights advocate
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_____ Employers' rights advocate
_____ Other: Specify _____

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